SUNRISE
SMILE DESIGN

PATIENT GOALS

Date: ___/___/_____ Patient Name: _____ Birth Date: ___/___/_____

PATIENT GOALS:

What is your goal for dental treatment today? _____

Are you in discomfort today? □ Yes □ No (If no, please explain below)

_____

Are you pleased with the appearance of your teeth? □ Yes □ No (If no, please explain below)

_____

Do you like your smile? □ Yes □ No

Do you wish your teeth were whiter? □ Yes □ No

Do you have old fillings or dental work that you don't like the look of? □ Yes □ No

Have you lost any teeth or have any teeth been removed? □ Yes □ No

Have they been replaced? □ Yes □ No (If yes, how?)

Are you happy with the replacement? □ Yes □ No

How can we help you improve your teeth and smile?

_____

Have you ever had a bad dental experience in a dental office? □ Yes □ No (If yes, please explain below)

_____

Does dental treatment make you nervous? □ Yes □ No

Have you been pleased with your previous dental care? □ Yes □ No