

The Park

Smile survey

Please complete the following to help us decide how we can best help you.
All information will be kept strictly confidential.

Name:

Consultation date:

Occupation:

1. How did you hear about our practice?

Advertisement (please specify)

Recommendation (please specify)

other (please specify)

2. What made you come to our practice?

3. Are you thinking about improving your smile for a special occasion?

Wedding Birthday Present Other (please specify)

4. Have you ever had any cosmetic treatment before, dental or otherwise?

5. Are you concerned about your Top Teeth Bottom Teeth Both

6. In order of importance which of the following concerns you most about your teeth? (1=least important - 10=most important)

Whiteness: Straightness: Size: Length:

Shape: Gaps: Metal Fillings: Gums:

7. On a scale of 1-10 (10 = good) how would you currently score your smile?

8. On a scale of 1-10 (10 = perfect) how perfect would you like your new smile to be?

