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BOSTON
Dental Care

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Cosmetic Questionnaire

With recent advancements in materials and techniques, many of our patients are inquiring about cosmetic dental procedures. In order to better serve you, please take a moment to let us know how you feel about the appearance of your smile.

Name: _____ Date: _____

	Yes	No
Are you happy with the appearance of your teeth?	☐	☐
Are you currently experiencing oral discomfort?	☐	☐
Are you missing any teeth?	☐	☐
Do you have any chipped teeth?	☐	☐
Do you have crooked or uneven teeth?	☐	☐
Are there gaps or spaces between your teeth?	☐	☐
Do your teeth have any discolorations, stains, or spots?	☐	☐
Would you be interested in whiter looking teeth?	☐	☐
Do you have existing silver fillings you would like changed to white?	☐	☐

From the questions above, what are your biggest concerns?

_____

_____

When was your last visit to a dentist?

_____

Does dental treatment make you nervous, and if so why?

_____

_____

If you could change anything about the appearance of your teeth, what would it be?

_____

_____

Thank you for taking the time to provide us with the above information. The survey will allow us to better cater toward your specific needs.