

Quality You Can See
Dr. Scott Sahf & Team

Name _____

Getting to Know You...

Date _____

Welcome to our practice! We're glad you've chosen to be our patient!

1. What do you like to do for fun or do you have any hobbies? _____

2. Today's dentistry allows us to enhance your smile quickly and easily.
How would you like your smile to look? How would you like your teeth/mouth to be?

Straighter

Longer

Replace missing teeth

More even

Close spaces

Fresher Breath

Shorter

Whiter

Replace old silver mercury fillings

Replace uncomfortable partials or dentures

Is there anything else you would like to change about your smile? _____

3. Do your gums bleed when brushing or flossing? _____

4. Have you been told you have gum disease? _____

5. Do you have any other areas that are concerning you? _____

6. Are there any special occasions coming up that would require a photograph? _____

7. Do you have any teeth that cause you pain & which part of the mouth? _____

8. When would you like to begin & what would you start with first? _____

9. Do you have TMJ or pain in your jaw joints? _____

10. Do you have pain in the muscles around your head, jaws, neck or shoulders? _____

11. Do you have frequent headaches or migraines? _____

12. Do you clench or grind your teeth? _____

13. Do you have ear congestion, vertigo or tinnitus(ringing in the ears)? _____

14. Do you wear a partial or full denture? _____