

PATIENT EVALUATION FORM

1. How did you hear about our practice? (check all that apply)
 - Referred by a friend / family member
 - TV Ad
 - Internet (Google, yahoo, msn, aol); I searched for (keyword) _____.
 - Mailer
 - Phone book
 - Walk by or drive by the practice

2. Date of your last hygiene visit: _____.

3. On a scale of 1 to 5 (1 being good, 5 being bad) please rate how you feel your overall dental health is.
GOOD 1 2 3 4 5 BAD

4. On a scale of 1 to 5 (1 being faithful, 5 being bad) Over the last ten years rate how faithfully you have had your teeth cleaned?
FAITHFUL 1 2 3 4 5 NOT FAITHFUL

5. On a scale of 1 to 5 (1 being not sensitive, 5 being very sensitive) what is your level of sensitivity to dental procedures?
NOT SENSITIVE 1 2 3 4 5 VERY SENSITIVE

6. On a scale of 1 to 5 (1 being not sensitive, 5 being very sensitive) what is your sensitivity to cleaning visits?
NOT SENSITIVE 1 2 3 4 5 VERY SENSITIVE

7. Rate how you feel about your smile and the look of your teeth. (1 being happy, 5 being unhappy).
HAPPY 1 2 3 4 5 UNHAPPY

8. Are you interested in regular hygiene cleanings?
 - Yes
 - No

9. What is the main reason for your visit today?

- Tooth pain
- I need a check-up
- Cleaning
- Whitening
- Cosmetic dentistry
- Sedation dentistry
- Other_____.

10. I would like to learn more about...

- Whitening
- Cosmetic dentistry
- Sedation dentistry
- Implants
- Bridges
- Veneers
- Dentures
- Other_____.

11. When would you like to get started?

_____.

12. Are there any special occasions coming up? Weddings; Reunions; Photo shoot?

_____.

13. What would you like to start with first?

_____.

I give Dr. Reilly permission to use my photographs, models, or treatment records for teaching purposes.

- Yes
- No

Patient's Signature

Date