Patient Goals

Patient Name_____ **Date of Birth**_____

SS/HIC/Patient ID#_____

What is your goal for dental treatment today?_____

_____

_____

_____

Are you in discomfort today? **Yes** **No**

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

Are you pleased with the appearance of your teeth **Yes** **No**
If no, please explain_____

_____

_____

Do you like your smile? **Yes** **No**
If no, please explain_____

_____

_____

Does dental treatment make you nervous? **Yes** **No**
If yes, please explain_____

_____

_____

Have you ever had a bad experience in a dental office? **Yes** **No**
If so, please explain_____

_____

_____

How can we help improve your teeth and smile?_____

_____

_____

Click to submit