Dental Profile

Patient_____ Date_____

	Yes	No
1. Do your gums bleed?	❑	❑
2. Do you feel you have bad breath?	❑	❑
3. Do you wish your teeth were whiter?	❑	❑
4. Do you like the way your teeth are shaped?	❑	❑
5. Are you pleased with the appearance of your smile?	❑	❑
6. Are you interested in cosmetic dentistry?	❑	❑
7. Are you interested in orthodontics?	❑	❑

8. On a scale from 1 - 10, how important is it for you to keep your teeth for a lifetime? (10 being very important) _____

9. On a scale from 1 - 10, how would you rate your apprehension with dental visits? (10 being very nervous) _____

10. Why did you leave your last dentist? _____

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