

Do you have an unpleasant taste or odor in your mouth? _____ Do you smoke? _____ How much? _____
Do you frequently snack between meals or chew gum? _____ Have you ever been instructed regarding proper
home care? _____ Has fear or discomfort kept you from regular dental visits? _____
Is there anything you would like to share with us that we have not mentioned? _____

PERSONAL SMILE EVALUATION

Please take a moment to answer these questions about your smile:

- 1) On a scale of 1-10 (1 being the lowest), rate your teeth and smile _____
- 2) Are your teeth crooked, crowded or worn? If so, are you concerned? _____
- 3) Do you have any spaces between your teeth that bother you? _____
- 4) Do you like the color of your teeth? _____
- 5) Have you ever considered how you'd feel with a brighter smile? _____
- 6) Do you like the shape of your teeth? _____
- 7) What changes would you like to make with the appearance of your smile? _____
- 8) Is there anything you'd like to share with us that we have not mentioned? _____

If we may assist you or answer any concerns you may have—please ask! We want to make your dental experience as pleasant as possible!

The above information is true and complete to the best of my knowledge. I consent to the treatment requested by me covering all aspects of routine dental care, including administration of x-rays, photos, local anesthetics, sedatives, nitrous oxide or combination. I consent to have an HIV or hepatitis test paid for by Dr. Frieder should any accidental exposures to any of the clinical personnel occur. I understand that perfect results cannot be guaranteed.

Signature _____ Date _____

CONSENT FORM FOR HYGIENE

I agree to occasionally receive dental hygiene services without a dentist in the office if I have been examined by Dr. Frieder within the past seven months. I understand a prescription for these services is written in my chart.

Signature of Patient _____ Date _____

Signature of Hygienist _____ Date _____

Consent for a Minor or Incompetent Adult

I, _____, as custodial parent or guardian of _____, consent to the occasional delivery of hygiene services to _____ without a dentist present if she/he has been seen by Dr. Frieder within the last seven months. I am aware that a prescription for dental hygiene services is written in the patient's chart.

Signature of Parent/Guardian: _____ Date _____

Signature of Hygienist: _____ Date _____