COMFORT MENU

Your comfort is our priority. We provide a variety of services to ensure that you are comfortable at all times. Please select from the following options:

• Patients find that if they take an analgesic prior to treatment it helps later in the day.
Which would you prefer? Tylenol Advil Other _____

• We provide various levels of sedation to ease your mind.
Would you benefit from a sedative?.....Yes ❑ No ❑

If yes, we provide:
❑ Nitrous Oxide (laughing gas)
❑ Mild sedative (oral medication) With mild sedative, you will need someone to drive you to and pick you up from the appointment.
❑ Intravenous sedation (IV) administered by a board certified anesthesiologist. With IV sedation, you will need someone to drive you to and pick you up from the appointment.

• Complimentary WiFi Internet access is available for your use throughout the office. Please feel free to bring your wireless Internet device with you for each visit.

• Blankets help keep you warm and relaxed through your visit.
Would you like a blanket?.....Yes ❑ No ❑

• Pillows provide an extra measure of comfort if you have a sore back or neck.
Would you like a pillow?.....Yes ❑ No ❑

• Is there anything else we can do for you to make your visit comfortable?

_____

_____

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DENTAL HEALTH AND APPEARANCE

Reason for visit: _____ Approximate date of last dental visit: _____
What is your primary concern that you would like us to address first? _____
When would you like us to start treatment? _____
Have you ever had any serious problem associated with previous dental treatment or any dental emergencies?…….Yes ❑ No ❑
If so, explain: _____
What, if anything, has happened in previous experiences at the dentist that was reason not to return? _____

_____
Do you have missing teeth?_____ If yes, have you had them replaced?_____
If you have had missing teeth replaced, are you happy with the results? _____
If not, would you like to learn about your options to replace them? _____
Do you ever feel (or have you ever been told) that you don't have fresh breath? _____
How often do you brush your teeth?_____ How often do you floss?_____ What type of brush do you use? Manual ❑ Powered ❑
Do you avoid brushing any part of your mouth because of pain? Yes ❑ No ❑ If yes, what part? _____
Which foods cause you twinges of pain: hot ❑ cold ❑ sweet ❑ sour ❑ none ❑ Do you lose fillings or break fillings?……..Yes ❑ No ❑
Do you chew on only one side of your mouth?……Yes ❑ No ❑ If yes, explain: _____
Do your gums feel tender or swollen?……..Yes ❑ No ❑ Do you usually have many cavities?…….Yes ❑ No ❑
Do you clench or grind your jaws while sleeping or during the day?……Yes ❑ No ❑ Do your jaws ever feel tired?……..Yes ❑ No ❑

We respect your right to choose the level of care that fits *your* needs. We've found that many adults are unaware that problems even exist. There are rarely symptoms (pain, bleeding) associated with the aging and deterioration of teeth and gums – until it is far too late. According to the ADA, more than 80% of adult Americans have some level of gum disease. With your permission we would like to explain the choices available to achieve long-term health and beauty for your existing natural teeth. Please check all that apply:

❑ I desire to keep my own teeth for life, if possible. I want my teeth to look good, feel good, and last for a long time.
❑ Spreading payments out over time may help me to achieve the excellent results I desire.
❑ Phasing treatment, by priority, over a few years may make it feasible for me to achieve the excellent results I desire.
❑ I am interested in a plan for long-term dental health. However, I am currently unable to pursue this, and would appreciate help with emergencies and cleanings for now.
❑ Although I am not interested in a plan for long-term dental health, I do desire an office who will treat teeth in need of immediate/ emergency attention, as well as keep me up to date on cleanings.

COSMETIC/ESTHETIC EVALUATION

Are you delighted with your smile? _____ Please rate your smile from 1 to 10 (1 = I hate my smile, 10 = awesome)_____
Would you like to have whiter teeth? ❑ Yes ❑ No
If you had a magic wand, what, if anything, would you change about your smile?_____
What (if any) personal or professional benefit might you gain if you had a gorgeous smile? _____
Do you have any special occasions coming up? _____

Through state-of-the-art technology of cosmetic dentistry, we have the ability to help you achieve a world-class smile, often overnight… Using Computer Assisted Dental Imaging and High Resolution Video Photography, we can simulate very closely how YOU would look after the improvements, PRIOR to any treatment! Imaging can be performed as part of your exam visit (at NO additional charge). Would you like to see what YOU would look like with a new and improved smile? Yes ❑ No ❑ If yes, please check off all that apply:

❑ Lighten all front teeth showing	❑ Rebuild fracture(s)	❑ Straighten rotation	❑ Eliminate dark or stained fillings
❑ Lighten single tooth	❑ Lengthen	❑ Straighten angulation	❑ Reduce gum showing in smile
❑ Close spaces between teeth	❑ Shorten	❑ Eliminate crowding	❑ Repair uneven edges

Please add anything you feel is important: _____

_____

At Better Image Dentistry, though our focus is on appearance-related dentistry, our team also delivers routine general dental care. With flexible payment plans as well as phasing treatment over time, you and your family can achieve spectacular long-term results. Thank you so much for the opportunity to be of service.

YOUR DENTAL NEEDS

Your Name: _____ Date: _____

Our office is like no other dental office. This will be the most important dental visit you will ever have. We place a high emphasis on helping you determine your present and future dental needs. Some things we will discuss during your first visit may be issues you have never considered before. Please check what best expresses how you feel about the following questions:

• Are you having any areas of concern? _____

• What do you think is the present state of your oral health? _____

_____

• What do you already know about our office and what are your expectations? _____

_____

• How healthy do you want us to get your mouth? (please circle)

The best it can be Average Don't really care

• Should you need treatment, at what point should we address it? (please circle)

When something isn't ideal When something is worsening When my tooth hurts or breaks

• What quality of dentistry do you want us to recommend? (please circle)

Ideal/the best Average Just patch it

• We have the ability to look at your mouth from three different perspectives. Please rank these in the order of most important to least important to you.

___ As a general dentist ___ As a cosmetic dentist ___ As a functional dentist

• How do you feel about the appearance of your face and smile? _____

_____

• What would it take for you to trust us to be your dentist? _____

_____

• Tell us about your good dental experiences. _____

• And the bad ones. _____

• Has fear ever been an issue for you in a dental office? _____

• What caused you to leave your last dental office? _____

• Has time ever been a factor in getting your dental work done? _____

• Has cost of dental treatment been a concern for you? _____

• What can we do to help you with this? _____

• Is there any additional information you would like us to know? _____