george family
DENTISTRY

Tell us about your smile!

Patient's name: _____ Date: _____

What is the reason for your dental visit today? _____

When was your last visit to the dentist (if at another office)? _____

Were X-rays taken at that visit? _____Yes _____No

Prior dentist's name, address and phone number:

_____

How often do you brush your teeth? _____

Do you floss? _____Yes _____No

If you could change anything about your mouth, teeth or smile what would it be?

_____

_____

_____

_____

_____

Who may we thank for referring you to our office?_____