

Dustin Nelson, DDS

TOTAL SMILE SOLUTIONS

Client individuality is very important to us.

Please answer the following questions so that we may better serve you. *Thank You!*

What is your primary goal in seeking our services? _____

Are you currently having areas of concern? _____

Is the present state of your mouth: **Good** _____ **Slightly Neglected** _____ **Neglected** _____

What quality of dentistry are you searching for? **Average** _____ **The best it can be** _____

Would you like for us to consult you for **Cosmetic Dentistry** _____ **General Dentistry** _____ **Both** _____

Would you like to change your smile? **Yes** _____ **No** _____

If yes, please explain _____

How long have you wanted to change your smile? **Child** ___ **Teen** ___ **Young Adult** ___ **Recent** ___

Have you had mostly **good** _____ or mostly **bad** _____ dental experiences?

How did you find us? _____

Why did you choose us? _____

How may we earn your trust? _____

Do you currently have a dentist? **Yes** _____ **No** _____

Have you had full mouth x-rays in the past 12 month? **Yes** _____ **No** _____

Are you fearful of dental treatment? **Yes** _____ **No** _____

Is time a factor in getting dental treatment? **Yes** _____ **No** _____

Is the cost of treatment a concern for you? **Yes** _____ **No** _____

Are there currently other financial commitments that will delay treatment? **Yes** _____ **No** _____

Do you want to discuss financing options? **Yes** _____ **No** _____

If so, how would you rate your credit? **Poor** ___ **Average** ___ **Good** ___ **Excellent** ___

Will you need to consult a family member regarding your treatment and the related costs? **Yes** _____ **No** _____

Name (please print)

Date