URN:_____ *(Office use only)*

Dental Information

1 Where was your last practice? _____

2 How long ago was your last appointment (*approximate date*):

Exam: _____ Hygienist:_____ Treatment _____

If 1 = poor and 10 = ideal, I would score my current smile:

1 2 3 4 5 6 7 8 9 10

I feel self conscious about my teeth when I smile ☐

I wish my teeth were whiter and brighter ☐

I wish my teeth were shaped differently ☐

I don't like the colour of my silver fillings ☐

Some of my teeth are discoloured ☐

I have crowns which don't match my natural teeth ☐

I wish my teeth were straighter ☐

My gums sometimes bleed when I brush them ☐

I am not sure my breath is fresh ☐

Are you anxious about receiving dental treatment ☐

If I could alter my smile, I would most like to change:

Why did you choose Hoburne Dental Practice: