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Today's advances in dental techniques and materials means that we are now more than ever able to help you achieve the smile you've always wanted.

Name: _____

Date of Last Dental Visit: _____

- | | Yes | No |
|---|-----------------------------|--------------------------|
| 1. Are you satisfied with the appearance of your teeth? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. On a scale of 1 - 10 (10 being the highest) how happy are you with your smile? | 1-2-3-4-5-6-7-8-9-10 | |
| 3. Are you self-conscious about your teeth when you smile? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you wish your teeth were whiter? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Do you wish your teeth were shaped differently? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Are your teeth crowded or spaced? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Do you have any discolored teeth that embarrass you? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Do your front teeth have fillings that do not match the color of your teeth? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. If you could change your smile, what would you most like to change? | | |
| <hr/> | | |
| <hr/> | | |
| 10. Do you wish the fillings in your back teeth were tooth colored? | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Do your gums appear red and swollen or bleed when you brush them? | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Do you suffer from bad breath - halitosis? | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Does your denture fit well and feel comfortable? | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Do you play a contact sport with a properly fitted sports mouth guard? | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Which statement best describes your feelings about visiting the dentist? | | |

I feel relaxed

I feel a little anxious

I feel very nervous

16. Are there any dental procedures that have frightened you in the past, or that you are very anxious about?
