ELITE SMILES
DENTAL LTD
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Our goal is to address all of our patient's needs and help you look and feel your personal best!

If the patient is an adult, please fill out this side.
If the patient is a minor, please fill out the back side.

In order to achieve the highest quality care, we encourage you to answer the following:

When I see a picture of myself, the first thing I notice is:

_____

_____

Do you have any concerns regarding past dental experiences?

_____

_____

Are there any other services you desire and think we could assist you with? Y or N
If yes, please explain _____

_____

- Are any of the following areas of concern? Please check all that apply
  - ☐ Frown lines between brows
  - ☐ Fine lines and wrinkles
  - ☐ Tired looking skin
  - ☐ Significant lines around nose and/or mouth
  - ☐ Wrinkles around eyes

- Do you like the way your teeth are shaped? Y or N
- Do you like the way your teeth come together? Y or N
- Are there dark areas above current crown or bridge work that concern you? Y or N
- Would you like your teeth to be whiter? Y or N
- Are any of your teeth yellow, stained or discolored? Y or N
- Would you like to change anything about the appearance of your teeth or smile? Y or N
- Do you have any missing teeth that need replacing? Y or N

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