MARTY W LINDAHL DDS PC
general • aesthetic • implant dentistry

Free Initial Consultation

Welcome! During your free initial consultation, we will do an abbreviated exam and discuss your overall goals. With that information, we will be able to provide you with general options for treatment, including examples of before and after cases that may be similar to your own. We can also discuss financial options available. The main purpose of this consultation is for you to meet our team and let us learn about the goals you have for your smile and oral health. Should you decide to go forward, we can then schedule you for a comprehensive exam where we will collect all of the data necessary to provide you with a specific treatment plan tailored to your goals as well as the fees involved. We love improving smiles and strive to make the process of smile makeovers as stress-free as possible!

Patient Information

Circle one: Mr. Mrs. Dr. Ms. Miss

Name:_____

Address:_____

City: _____

State: _____

Zip: _____

Hm# _____ Cell#_____

Dental History

Are your teeth sensitive to: ☐ Heat ☐ Cold ☐ Pressure ☐ Sweets

Do you have any fear of dental work? ☐ Yes ☐ No

What, if anything, has happened in previous experiences at the dentist that was reason not to return? _____

_____

How would you describe the condition of your teeth and gums?

☐ Good ☐ Fair ☐ Poor

Are you currently in pain or discomfort with your teeth or gums?

☐ Yes ☐ No If yes, please explain: _____

How often do you brush your teeth? _____ Floss? _____

Do your gums bleed when you brush? ☐ Yes ☐ No

Do your gums bleed when you floss? ☐ Yes ☐ No

Have you ever experienced pain in your jaw joint? ☐ Yes ☐ No

Have you ever been treated for TMJ symptoms? ☐ Yes ☐ No

If yes, please explain: _____

Do you grind or clench your teeth? ☐ Yes ☐ No

Cosmetic/Esthetic Evaluation

Are you delighted with your smile?_____ Please rate your smile from 1 to 10 (1=I hate my smile, 10=awesome) _____

Would you like to have whiter teeth?_____

If you had a magic wand what, if anything, would you change about your smile?_____

Do you have any special occasions coming up?_____

Please indicate which of the following would be of interest to you:

☐ Lighted all front teeth showing	☐ Rebuild fracture(s)	☐ Straighten rotation	☐ Eliminate dark of stained fillings
☐ Lighten single tooth	☐ Lengthen	☐ Straighten angulation	☐ Reduce gum showing in smile
☐ Close spaces between teeth	☐ Shorten	☐ Eliminate crowding	☐ Repair uneven edges

Please add anything you feel is important for us to know: _____

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