Patient Intake Form

What are your main dental concerns that you are hoping to find a solution for?

How are these concerns affecting your day to day life?

How important are the following areas to you?

	Not Important		Somewhat Important		Very Important
Alleviating Pain:	1	2	3	4	5
Increasing Confidence:	1	2	3	4	5
Improving Eating:	1	2	3	4	5

You will be able to ask any questions during your consultation. Is there an important question or concern in particular you want to make sure we discuss?

Is there anyone else involved in the decision making for your dental healthcare? If so, who?

Have you seen another doctor for your current dental condition? If so, what did they treatment plan for you?