COASTAL
DENTAL CARE

EVALUATE YOUR SMILE

Name: _____ **Date:** ____/____/____

Do you have sensitive teeth? Yes / No
If yes, Explain:

Do you have any chipped or broken teeth? Yes / No
If yes, Explain:

Are you happy with the color of your teeth? Yes / No

Would whitening your teeth interest you? Yes / No

Would you like to change the appearance of your teeth? Yes / No
If yes, Explain:

Would you be interested in replacing your
silver fillings to a cosmetic white filling? Yes / No

Would you be interested in INVISALIGN treatment?
A clear way to straighten your teeth? Yes / No