

Meadowlark
Dental
Associates



Patient Cosmetic Form

Is there anything about your smile that you do not like?

Are you interested in knowing the options available for a more beautiful smile?

Do you like the appearance of your teeth?

Are all of your teeth in alignment (straight)? _____

Do you have any missing teeth? _____ Are any chipped? _____

Is your bite comfortable when chewing, biting?

Do you have frequent headaches? _____

Do you have any old fillings or dental treatment that you are unhappy with?

What would you like to change the most about the appearance of your teeth?

Is there anything else that you would like us to know? _____

PATIENT PHOTO CONSENT FORM

The following form gives permission to Meadowlark Dental Associates, P.C. to take photos as part of my dental record. These photos taken in our office may be used for case presentations as well as continuing education. I hereby give you permission to use the following type of photos:

FACE _____

TEETH _____

Before and after photos may be used to present future case studies to patients, used on our dental web site, as well as in our office slide show.

Thank you for your time and cooperation.

Signature _____ **Date** _____