Treatment Goals for Dental Rehabilitation

To facilitate your care we would like to get information pertinent to your goals that will make it more efficient to develop an appropriate treatment plan for you. To assist us in establishing the best treatment plan for you please answer the following questionnaire:

Date:_____

Name:_____

My goals in restoring my mouth are:

_____
_____
_____

The goals in my care are primarily: ☐ Esthetic / ☐ Functional Improvement

If needed I am willing to utilize the following to assist in my care:

Dental Implants: ☐ Yes ☐ No
Orthodontics (Braces): ☐ Yes ☐ No
A removable Prosthesis such as a partial or complete denture: ☐ Yes ☐ No

I would like a treatment plan that is dependent on the following time constraints:

☐ I would like to start my treatment as soon as possible.
☐ I would like to delay starting my treatment until: _____
☐ Complete my work by: _____
☐ There are no time constraints to my care.

I would like a treatment plan developed for me that fits into the following budget:

☐ I would like to spend no more than: _____
☐ I would like the most optimal treatment plan regardless of cost.
☐ I would like the most optimal treatment available but may have to space out the payments and would, therefore, like to do my treatment in stages or consider a financing program.

If there are any other considerations you would like us to make please list them here:

_____
_____
_____
_____
_____
_____

Signed: _____

Relation to Patient: ☐ Self / ☐ _____