LUMINEERS® BY CERINATE® SMILE EVALUATION

A Simple Quiz to Help You Obtain the Smile You've Always Wanted

NO PAIN—YOU DON'T EVEN NEED AN ASPIRIN.

THE MOST SIGNIFICANT COSMETIC ADVANCEMENT...EVER!

Hold a mirror 12"–14" from your face. Smile to show your teeth. Take the time to observe your teeth carefully, then answer the following questions. If you are not happy with the appearance of your teeth, ask your dentist how LUMINEERS can improve your smile.

1 Do you like the appearance of your teeth; your smile? ❑ Yes ❑ No
If not, explain _____
_____

2 Are your teeth all in alignment (straight)? ❑ Yes ❑ No
If not, explain _____
_____

3 Do you have spaces that you don't like? ❑ Yes ❑ No
If yes, explain _____
_____

4 Do you like the color of your teeth? ❑ Yes ❑ No
If not, explain _____
_____

5 Do you like the shape of your teeth? ❑ Yes ❑ No
If not, explain _____
_____

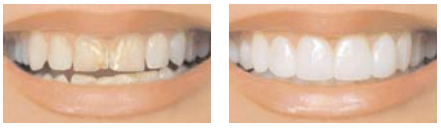
6 Are your teeth...
chipped?_____protruding?_____hidden?_____
_____

7 Are your teeth wearing on the biting surfaces? ❑ Yes ❑ No
If yes, explain _____
_____

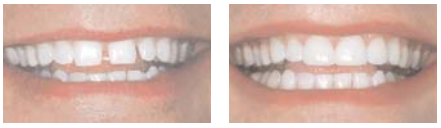
8 Are there old fillings or dental work you don't like looking at? ❑ Yes ❑ No
If yes, explain _____
_____

9 What would you like to change the most in the appearance of your teeth?
_____
_____

10 How would you like your teeth to look?
_____
_____
_____

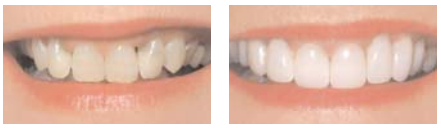


Stained and Chipped

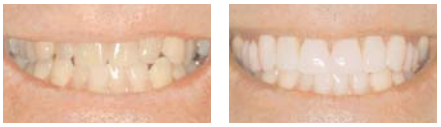


Spaces

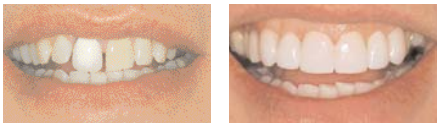
Calcification Stains



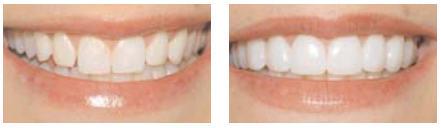
Fanged Teeth



Stained and Crooked Teeth



Porcelain Crowns



Beautiful Smile

YOUR SMILE IS THE EASIEST WAY TO IMPROVE YOUR APPEARANCE!

LUMINEERS® BY CERINATE®
lumineers.com

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Health History

Mr. Mrs. Miss _____ Birthdate_____ Age_____ Soc. Sec. No._____

Home address_____ City_____ State_____ Zip_____ Phone_____

Dental insurance_____ Group or Plan No._____ Referred By_____

Person financially responsible_____ Relationship to you_____ Soc. Sec. No._____

Spouse name_____ Birthdate_____ Employer_____ Soc. Sec. No._____

Occupation_____ Employer_____ Phone_____

Person to contact in case of emergency_____ Phone_____

Medical History

Physician_____ Address_____ Phone_____

Are you in good health?_____ If no, explain_____

Do you have an existing illness?_____ If yes, explain_____

Have you been hospitalized in the past two years?_____ If yes, explain_____

Do you bleed excessively when cut?_____ Do you smoke?_____ If yes, how much?_____

Are you taking any medication, pills or drugs?_____ If yes, please list:_____

Do you now have, or have you had any of the following? (If yes, describe under remarks.)

		YES	NO			YES	NO
1.	Heart Disease	❑	❑	14.	Liver Disease	❑	❑
2.	High Blood Pressure	❑	❑	15.	Kidney Disease	❑	❑
3.	Blood Disease	❑	❑	16.	Hepatitis	❑	❑
4.	Rheumatic Fever	❑	❑	17.	Asthma	❑	❑
5.	Heart Murmur	❑	❑	18.	Tuberculosis	❑	❑
6.	Diabetes	❑	❑	19.	AIDS or HIV positive	❑	❑
7.	Stroke	❑	❑	20.	Allergy to: (a) Penicillin	❑	❑
8.	Epilepsy	❑	❑		(b) Other Antibiotics	❑	❑
9.	Arthritis	❑	❑		(c) Local Anesthetics	❑	❑
10.	Tumor History	❑	❑		(d) Other	❑	❑
11.	VD	❑	❑	21.	Are you pregnant?	❑	❑
12.	Nervous Disorders	❑	❑	22.	Have you ever used Fen-Phen?	❑	❑
13.	Radiation Treatment	❑	❑				

Dental History

Do you have any present dental complaints? ❑ Yes ❑ No What?_____

When was your last full-mouth X-ray taken?_____ Where?_____

When was your last cleaning?_____ Where?_____

Have you ever been instructed in the prevention of decay?_____

Have you ever been instructed in caring for your gums?_____

Remarks

_____

_____

I consent to whatever dental procedures and anesthetics are necessary for the treatment of the above named patient.

I also agree to assume full financial responsibility for all treatment rendered.

Signature_____ Date_____