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1. What made you select our office? _____

2. What has been the nature of your past dental experiences? _____

3. Is there anything you don't like about your smile?

4. What bothers you most about your teeth? _____

5. Do your gums bleed? _____

6. Do you suffer from frequent headaches? _____

7. Are any areas of your mouth sensitive? To what? _____

8. Does food pack between your teeth? _____

9. Do you wish your teeth were whiter? _____

10. Have any problems occurred during the course of your past dental care?

