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

LUMINEERS™ BY CERINATE® SMILE EVALUATION

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?_____

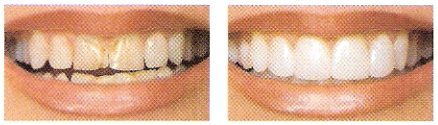
7 Are your teeth wearing on the biting surfaces? ❑ Yes ❑ No
If yes, explain _____

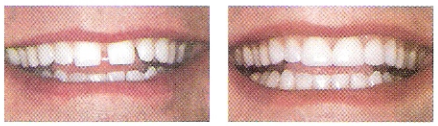
8 Are there old fillings or dental work you don't like looking at? ❑ Yes ❑ No
If yes, explain _____

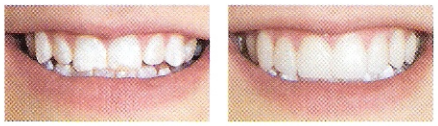
9 What would you like to change the most in the appearance of your teeth?
_____

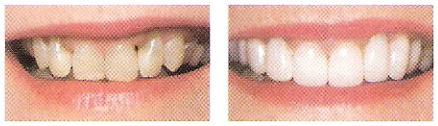
10 How would you like your teeth to look?
_____

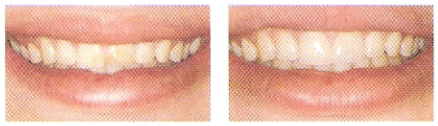
These smiles were achieved painlessly!

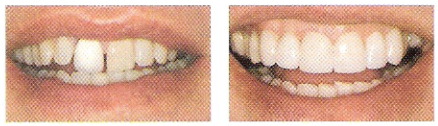

Stained and Chipped

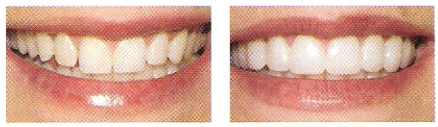

Spaces


Hypocalcification Stains


Fanged Teeth


Chipped Teeth


Porcelain Crowns


Beautiful Smile

YOUR SMILE IS THE EASIEST WAY TO IMPROVE YOUR APPEARANCE!

LUMINEERS™
BY CERINATE®
cerinate.com

Cerinate Smile Design Studios, 2727 Skyway Drive, Santa Maria, CA 93455 • 800-972-1236 • www.cerinate.com

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? _____ 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 _____