Patient Smile Analysis:

Please help us to meet your needs by answering a few questions for us. Thank you!

Patient Name _____ Date _____

Please tell us about your past dental experiences. What, if any concerns do you have regarding the dental experience?

_____

_____

How healthy do you feel your mouth is on a scale of 1-10 (10 being the healthiest)? Please tell us more about this.

_____

_____

_____

If you could change anything about your teeth, what would it be?

_____

_____

Has dentistry ever been presented to you that you chose not to complete? If so, what?

_____

_____

Do you smoke or use smokeless tobacco?

_____

Please mark an X by the statements below that you agree with

____ I would like to have a nicer smile.

____ I wish the color of my teeth were whiter.

____ I think some of my teeth are too big.

____ I think some of my teeth are too small.

____ My teeth are crowded and crooked.

____ My teeth are stained or discolored.

____ I cover my mouth when I smile.

____ My gums are red, swollen, receding and/or bleeding.

____ I don't like the spaces between my teeth.

____ My teeth are chipped and worn with rough edges.