

# 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?

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

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

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

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Do you smoke or use smokeless tobacco?

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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.