

/ /

Patient name

Date of birth

YES

NO

1. Are your teeth sensitive to:
- Heat
- Cold
- Sweets
- Biting pressure
2. Does food get stuck between certain teeth
3. Do you get frustrated because you always have something to be treated or repaired when you visit the dentist?
4. Are you dissatisfied with your teeth in any way? please explain
5. Are you dissatisfied with the way your teeth look? For example... color, shape, spaces, etc.
6. Do any of your fillings show when you talk or smile?
7. If any of your mercury/amalgam fillings need replacement would you prefer to have a more natural, tooth colored restoration instead?
8. Have you ever had any teeth removed? How long ago? _____
9. Do your gums bleed when brushing?
10. Do you ever avoid any part of the mouth while brushing or flossing?
11. Have you been instructed regarding proper dental home care?
12. Do you have an unpleasant taste or odor in you mouth?
13. Do you smoke or use any other tobacco products?
14. Do you frequently snack on sweets or chew gum between meals?
15. How often do you brush your teeth? _____ Floss? _____
16. Do you want to learn to control dental disease and retain your teeth?
17. Has the fear of discomfort kept you from regular dental visits?
18. Are you interested in sedation?
- Have you ever had sedation dentistry? _____ When? _____

19. When was your last dental visit? _____
20. What was done? _____
21. When was your last *thorough* exam with *full mouth x-rays* and/or diagnostic procedures? _____
22. Why did you leave your last dental office? _____
23. What prompted you to seek dental care at this time with this office?

SMILE ASSESSMENT FORM

Please consider each statement carefully and circle **Y** or **N**. During your exam today the doctor and members of the team will discuss your responses with you in confidence.

- | | | |
|---|---|---|
| 1. I am concerned about the appearance of my teeth or smile | Y | N |
| 2. I am concerned about the whiteness/lack of whiteness of one or more of my teeth. | Y | N |
| 3. I am concerned about the position or angle of one or more of my teeth. | Y | N |
| 4. I am concerned about the shape of one or more of my teeth | Y | N |
| 5. In social situations, I am sometimes embarrassed by my teeth or smile. | Y | N |
| 6. There are some things about my upper front teeth that I would like to change. | Y | N |
| 7. There are some things about my lower front teeth that I would like to change. | Y | N |
| 8. I have old fillings or previous dental treatment that is no longer satisfactory to me. | Y | N |
| 9. My bite is sometimes uncomfortable when I chew or bite. | Y | N |
| 10. I am interested in learning more about cosmetic dentistry. | Y | N |
| 11. I am interested in learning more about anxiety/sedation | Y | N |
| 12. I am interested in learning more about tooth replacement. | Y | N |

Please use the space below to indicate any other problems, concerns or questions you have. We will make every effort to listen attentively to your concerns so that we can present you with the best possible treatment options. Thank You!