SMILE ASSESSMENT FORM

Please consider each statement carefully and circle YES OR NO.

The doctor and members of the dental team will discuss your responses with you in confidence.

1. I am concerned about the appearance of my teeth or my smile. Y or N
2. I am concerned about the whiteness/lack of whiteness of one or more of my teeth. Y or N
3. I am concerned about the position or angle of one or more than one of my teeth. Y or N
4. I am concerned about the shape of one or more than one of my teeth. Y or N
5. In social situations, I am sometimes embarrassed by my teeth or my smile. Y or N
6. There are some things about my upper front teeth that I would like to change. Y or N
7. There are some things about my lower front teeth that I would like to change. Y or N
8. I have old fillings or previous dental treatment that is no longer satisfactory to me. Y or N
9. I am missing one or more of my teeth. Y or N
10. I am interested in learning more about esthetic dentistry. Y or N

DENTAL HISTORY

Name: _____

What is the main reason for your visit today? _____

When was your last dental exam? _____

How do you feel about the condition of your mouth? _____

What would you improve? _____

Does The thought of dental care make you nervous? _____ Yes _____ No

If yes, what is most bothersome? _____

Previous Dentist' s Name: _____

Why did you leave your former dentist? _____

How often do you:

A. Have dental examinations and cleaning? _____

B. Brush your teeth? _____

C. Floss your teeth? _____

What other dental aids do you use? (Interplak, toothpick, etc.) _____

Are your teeth sensitive to:
Hot or Cold? Sweets? Biting or Chewing?

Do You:

Clench or grind your teeth? While asleep or awake?	Yes__	No __
Bite/chew your lips or cheeks?	Yes__	No __
Hold foreign objects with your teeth? (pen, pipe)`	Yes__	No __
Mouth breathe while asleep or awake?	Yes__	No __
Smoke/chew tobacco?	Yes__	No __
Tend to get cold sore or fever blisters?	Yes__	No __
Experience frequent bad breath or dry mouth?	Yes__	No __
Have difficulty chewing? Experience jaw clicking or popping?	Yes__	No __
Have frequent stress or tension-type headaches?	Yes__	No __

Have you ever had: Orthodontic treatment? Oral surgery? Periodontal treatment? Bite adjustment? Serious injury to the mouth or head? Yes__ No__
If yes, please describe:_____

Have you ever had an upsetting dental experience? Yes__ No__ If yes, please explain:
_____