SMILE EVALUATION

NAME: _____ DATE: _____

Is there anything about your smile you don't like? Y / N

Do you like the appearance of your teeth? Y / N

Are your teeth all in alignment (straight?) Y / N

Have you ever considered orthodontic treatment (braces) Y / N

Do you have any missing teeth? Y / N Are any chipped? Y / N

Is your bite comfortable for chewing, biting? Y / N

Do you have frequent headaches? Y / N

How often? _____ Migraines? Y / N

Do you have any old fillings or dental work that you don't like? Y / N

Is there anything about the appearance of your teeth that you'd like to change? Y / N

Shade / Color Shape / Position Spacing / Gaps Crowding / Overlapping

DENTAL HISTORY

Are you nervous about dental treatment? Y / N

Have you ever had/needed Nitrous Oxide (gas) for treatment? Y / N

Is there anything about your mouth that concerns you now? Y / N

If yes: _____

Are any of your teeth mobile (loose)? Y / N

Have you ever been told that you have gum disease? Y / N

Have you had treatment for gum disease? Y / N When? _____

Do you smoke? Y / N Chew Tobacco? Y / N

Do you feel you have unpleasant breath at times? Y / N

How would you describe your dental health? Good Fair Poor

Do you have any questions regarding dental health? Y / N

If Yes: _____

Do you snore? Y / N Do you have sleep apnea? Y / N

Have you ever been told you clench or grind your teeth during sleep? Y / N

Do you now wear or have you ever worn a night guard appliance? Y / N

REMARKS

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