

SMILE ANALYSIS

Name _____ Today's Date _____

When was your last professional cleaning? _____

How often do you have your teeth cleaned? _____

Would you like to be notified when it is time for your next professional cleaning? Yes No

How do you feel about dental visits? Relaxed Anxious Neutral

How often do you brush your teeth? _____

How often do you floss your teeth? _____

Do you grind or clench your teeth? Yes No

Do you bite your fingernails? Yes No

Do you chew on pens or pencils? Yes No

Do you smoke? Yes No

Do you drink coffee or hot tea? Yes No If yes, how many combined cups per day? _____

Do you drink ice tea or colas? Yes No If yes, how many per day? _____

When you look in the mirror, do you like the appearance of your teeth? Yes No

Do you have any stained teeth? Yes No

Do you like the color of your teeth? Yes No

Do you have any spaces between your teeth? Yes No

Do you have any teeth with white spots? Yes No

Do you have any chips or cracks in your teeth? Yes No

Do you like the length of your teeth? Yes No

If your smile looks prematurely aged, would you like your smile to look ten years younger? Yes No

Do you have any crooked teeth? Yes No

Do you like the shape of your teeth? Yes No

Do you have any sensitive teeth? Yes No

Do you have any areas where your gums have receded? Yes No

Are you missing any teeth? Yes No

If yes, would you like to have the missing teeth replaced? Yes No

Do you have any unattractive silver fillings that you would like to eventually replace with tooth-colored fillings? Yes No

Do you have any teeth that you believe need caps or bonded porcelain inlays? Yes No

Do you have any caps that are not as attractive as you would like or have metal showing through? Yes No

Did you have orthodontic (braces) in the past? Yes No If yes, are you pleased with the results? Yes No

Would you like your children's teeth protected with bonded dental sealants? Yes No

Does too much gum tissue show when you smile? Yes No

Have you had any tooth bonding done in the past? Yes No

Have you ever had or considered cosmetic surgery? Yes No

Would you like to see what you would look like with a great looking smile? Yes No

Arts District Dentistry