SMILE ASSESSMENT

Patient:_____ Today's date:_____

Yes	No	
☐	☐	Are you happy with the appearance of your teeth?
☐	☐	Do you like the color of your teeth?
☐	☐	Do you have unsightly crowns or fillings?
☐	☐	Are your teeth sensitive to hot, cold, sweets, or pressure?
☐	☐	Are you concerned about your gums receding?
☐	☐	If you have missing teeth, are you interested in replacing them?
☐	☐	Are you familiar with the benefits of dental implants?
☐	☐	Do you have any clicking, popping, or discomfort with your jaw?
☐	☐	Have you had any orthodontic treatment?
☐	☐	Have you had any gum treatment or surgery?

How would you rate your smile on a scale of 1-10 (with 10 being the best)? _____

What would you like it to be? _____

What is holding you back from having the dental health (function or appearance) that you want?

☐ Fear ☐ Time ☐ Cost Other _____