

# SMILE EVALUATION

Name: \_\_\_\_\_

Date: \_\_\_\_\_



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

Do you like the appearance of your teeth?

Do you have any missing teeth?                      Any chipped?

Is your bite comfortable for biting or chewing?

Do you have any frequent headaches?

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

What would you like to change the most in the appearance of your teeth?

Are you aware of the new techniques in dentistry?

If the "Tooth Fairy" could grant you a dental wish, what would it be?

## DENTAL HISTORY

Are you nervous about dental treatment?

Is there anything about your mouth that concerns you now?

What type of toothbrush do you use?    Soft     Medium     Hard

Do you use dental floss?                      Tooth picks?                      How often?

Are any of your teeth mobile (loose)?

Do you feel you have any unpleasant breath at times?

How would you describe your dental health?

<u>REMARKS</u>