

Name: _____

Birthdate: _____

Smile Evaluation

Whom may we thank for referring you to our office? _____

What brought you in today? Are you experiencing any pain or have any specific concerns?

How long since your last dental visit? _____

When was the last time your teeth were cleaned? _____

If you could change just one thing about your front teeth, those we see when you smile

What would that be? _____

How do you feel about the color of your front teeth,
are they white enough?

Yes No

Do you like the way they are shaped?

Yes No

Are your front teeth as straight as you'd like them to be?

Yes No

Are you satisfied with their overall appearance?

Yes No

Is there anything you'd like to change about them?

Yes No

Now let's talk about your back teeth, the ones you chew on:

If there was anything you could change about these or anything specific you would like us to check,
what would it be? _____

Do you have any sensitivity to hot or cold when you chew?

Yes No

Do you have any difficulty chewing?

Yes No

Have you lost any teeth, or have any been removed?

Yes No

Have they been replaced?

Yes No

Are you happy with the replacement?

Yes No

Is the replacement comfortable?

Yes No

Does food get trapped and annoy you?

Yes No

Do you clench or grind your teeth?

Yes No

Does your jaw click or pop?

Yes No

Have you experienced any pain or soreness in the muscles
of your face or around your ears?

Yes No

Do you have frequent headaches, neck aches or shoulder aches?

Yes No

Finally, lets get a little information on your gums, which are always important to good oral health:

Do your gums ever bleed?

Yes No

Do you ever experience any sensitivity?

Yes No

Have you ever had any gum treatment or surgery?

Yes No

What? _____

When? _____

Where? _____

Do you have any recession?

Yes No

Do you feel your breath is offensive at times?

Yes No

Have you had any orthodontic work?

Yes No

Have you ever had any problems or complications with
previous dental treatment?

Yes No

If yes, explain:
