

Smile Analysis

Today's date _____

Patient Number _____

1. Do you love the way your smile looks? Yes No

2. Do you feel comfortable showing your teeth when you laugh or smile? Yes No

3. If you could change anything about your smile, it would be (check all that apply):

- | | | |
|---|--|--|
| <input type="checkbox"/> Color of your teeth | <input type="checkbox"/> Too much or too little of teeth show when you smile | <input type="checkbox"/> Gaps between your teeth |
| <input type="checkbox"/> Size/Shape of your teeth | <input type="checkbox"/> Too much or too little of gum shows when you smile | <input type="checkbox"/> Alignment of your teeth |
| <input type="checkbox"/> Other: _____ | | |

4. Do you have (check all that apply):

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Sensitive or receding gums | <input type="checkbox"/> Worn/broken/chipped teeth | <input type="checkbox"/> Old or discolored fillings | <input type="checkbox"/> Missing teeth |
| <input type="checkbox"/> Old crowns that have dark edges at the top | | <input type="checkbox"/> Other: _____ | |

5. In your line of work or lifestyle, do you (check all that apply):

- | | | | |
|--|---------------------------------|---|---------------------------------------|
| <input type="checkbox"/> Visit businesses or clients | <input type="checkbox"/> Travel | <input type="checkbox"/> Speak publicly | <input type="checkbox"/> Other: _____ |
|--|---------------------------------|---|---------------------------------------|

6. If you had a smile makeover do you think you'd feel (check all that apply):

- | | | |
|---|--|---------------------------------------|
| <input type="checkbox"/> More confident | <input type="checkbox"/> More optimistic | <input type="checkbox"/> Healthier |
| <input type="checkbox"/> Just OK | <input type="checkbox"/> No different | <input type="checkbox"/> Other: _____ |

7. Do you or someone in your family have issues with any of the following (check all that apply):

- | | | |
|---|---|----------------------------------|
| <input type="checkbox"/> Chronic bad breath | <input type="checkbox"/> Grinding teeth | <input type="checkbox"/> Snoring |
| <input type="checkbox"/> Other: _____ | | |

We'd like to know more about you so we can better serve you!

8. Do you prefer appointments in the (check all that apply):

- | | | |
|--|--|--|
| <input type="checkbox"/> Early morning | <input type="checkbox"/> Early afternoon | <input type="checkbox"/> No preference |
| <input type="checkbox"/> Late morning | <input type="checkbox"/> Late afternoon | <input type="checkbox"/> Other: _____ |

9. What are your favorite hobbies or activities?

10. Do you have children and grandchildren? If so, please list their names and ages.

11. Is there anything else that you want our office to know about you that will help us to serve you better?

