**SMILE EVALUATION**

1. If you could change anything about your smile, what would you change?
2. Would you like your teeth to be whiter? ☐Yes ☐No
3. Would you be interested in braces/Invisalign? ☐Yes ☐No
4. Do you have missing teeth that you would like to replace? ☐Yes ☐No
5. Do you have old silver-like fillings that you would like to be replaced with tooth-colored fillings? ☐Yes ☐No
6. Do you have any fears or anxiety about dental work? ☐Yes ☐No
7. Do you do excessive snoring? ☐Yes ☐No

**DENTAL HISTORY**

 Date of Last Dental Visit:

☐I don't know exact date    ☐Last 6 months    ☐6 months - 1 year    ☐1 -3 years    ☐Greater than 4 years    ☐Never

Date of Last Dental X -ray:

☐I don't know exact date    ☐Last 6 months   ☐ 6 months - 1 year   ☐ 1 -3 years    ☐Greater than 4 years    ☐Never

**ORAL HEALTH**

Have you ever been treated for periodontal (gum) disease?    ☐Yes ☐No

Have you ever had Novocaine or other local anesthetic?    ☐Yes ☐No

How happy are you with your smile (1-10)?  \_\_\_\_\_\_\_\_\_\_

Are you currently wearing Dentures? ☐Yes ☐No

Age of dentures: ☐Less than 6 Months ☐6 months -3 years ☐Greater than 4 years

Please check any conditions that apply to you below:

☐Pain In Jaw (TMJ) ☐Teeth Grinding/Clenching ☐Use Tobacco Products ☐Mouth Sores ☐Sensitive Teeth ☐Broken/Loose Teeth ☐Difficulty Chewing/Swallowing ☐Swollen/Bleeding Gums

Patient’s Name (print) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_