Smile Evaluation

Thank you for providing us with important information about yourself that will help us create your perfect smile!

1. **Are you having any discomfort in your mouth?** □ YES □ NO

   If yes please explain:
   _____
   _____

2. **How long since your last dental visit?**
   _____

3. **Do you have sensitivity to hot, cold, sweets, or chewing?**

   □ YES □ NO

   If yes which one?
   □ Hot □ Cold □ Sweets □ Chewing

4. **Does Dental treatment make you nervous?** □ YES □ NO

5. **Have you ever experienced any of the following problems?**

   - Bleeding Gums □ YES □ NO
   - Bad Breath □ YES □ NO
   - Unpleasant taste □ YES □ NO
   - Clenching/Grinding □ YES □ NO
   - Food wedging between teeth □ YES □ NO
   - Jaw clicks □ YES □ NO
   - Braces/Dental appliance □ YES □ NO
   - Root Canal □ YES □ NO
   - Periodontal treatment □ YES □ NO
   - Growth or sore spots □ YES □ NO
   - Teeth separation □ YES □ NO
   - Headaches □ YES □ NO
   - Snoring □ YES □ NO

6. **Have you ever had any teeth extracted?**

   □ YES □ NO

   If yes, have they been replaced in order to prevent shifting and tipping of remaining teeth and bite collapse:

   □ YES □ NO

7. **Do you wear dentures or plates?**

   □ YES □ NO

   If yes, are you satisfied with your present denture?

   □ YES □ NO

8. **On a scale of 1-10 (10 being the highest rating)**
   Please Circle One

   How important is your dental health to you?
   1 2 3 4 5 6 7 8 9 10

   Where would you rate your current dental health?
   1 2 3 4 5 6 7 8 9 10

   Where would you like your dental health rating to be?
   1 2 3 4 5 6 7 8 9 10

   Where would you rate the quality of your sleep?
   1 2 3 4 5 6 7 8 9 10

9. **Do you think your dental health affects your overall health?**

   □ YES □ NO

10. **Do you think it is important to have your teeth cleaned at least every six months?**

    □ YES □ NO

11. **Date of your last cleaning:**

    _____ / _____ / _____

12. **When was the last time you had an oral cancer exam?**

    _____ / _____ / _____

13. **What is the most important thing to you about your future smile and dental health?**

    _____
    _____
    _____
    _____
    _____
    _____

14. **How often do you brush your teeth?**
    _____

15. **What type of toothbrush do you use?**
    Please Circle One

    Hard Medium Soft Electric

16. **How often do you floss your teeth?**
    _____

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17. Is the brightness of your teeth important to you?

□ YES □ NO

18. Do you smoke or use tobacco products?

□ YES □ NO

19. If you could change anything about your teeth would you change:

- Straightness □ YES □ NO
- Close Spaces □ YES □ NO
- Replace Black/Silver Fillings with tooth Colored ones □ YES □ NO
- Repair Chipped Teeth □ YES □ NO
- Replace Missing Teeth □ YES □ NO
- Replace Old Crowns or Caps that don't match □ YES □ NO
- Less Gum Showing □ YES □ NO
- Be able to chew better □ YES □ NO

20. Do you expect to lose any teeth?

□ YES □ NO

21. Has anyone ever made you feel bad about your teeth or homecare?

□ YES □ NO

22. What is the most important thing to you about your dental visit today?

_____
_____
_____

23. Have you ever had a bad experience in a dental office?

□ YES □ NO

If yes please explain:

_____
_____
_____
_____

24. Sleepiness Scale

For each situation, decide whether or not you would have:

- No chance of dozing = 0
- Slight chance of dozing = 1
- Moderate chance of dozing = 2
- High chance of dozing = 3

Write down the number corresponding to your choice for each scenario:

- Sitting and Reading ____
- Watching TV ____
- Sitting inactive in a public place (theater or a meeting) ____
- As a passenger in a car for an hour without a break ____
- Lying down to rest in the afternoon when circumstances permit ____
- Sitting and talking to someone ____
- Sitting quietly after a lunch without alcohol ____
- In a car, while stopped for a few minutes in traffic ____

Total Score: ____