

Smile Analysis (21+)

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| Patient Name: | Date: |

What do you expect from a preventative cleaning? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. On a scale of 1-10 how would you rate your apprehension with dental visits?

(10 being very apprehensive) 1-2-3-4-5-6-7-8-9-10

1. On a scale of 1-10 how important is it to keep your natural teeth?

(10 being very important) 1-2-3-4-5-6-7-8-9-10

Yes/No Are you familiar with nitrous gas?

Yes/No Do your gums bleed?

Yes/No Do you feel you have bad breath?

Yes/No Are you familiar with periodontal disease?

Yes/No Do you wish your teeth were whiter?

Yes/No Are you familiar with in-office whitening?

Yes/No Do you like the way your teeth are shaped?

Yes/No Do you use an electric toothbrush, if so what brand/model? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Yes/No Are you interested in orthodontics?

Yes/No Are you happy with your smile?

Yes/No Do you wear dentures? What year were they made? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* If yes, are you happy with the feel and look of your dentures? Yes/No

Yes/No Did you know the ADA recommends getting new dentures every 5 years?

Is there anything you would like to change about your smile? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| Additional comments: (staff use only) |