SMILE ANALYSIS

Name: _____ **Date:** _____

1. How long has it been since you have last seen a dentist? _____
_____
2. Are your teeth sensitive to hot, cold, sweets or pressure? _____
_____
3. Would you say that your present dental health is good or bad? _____
_____
4. Would you like to know about permanent replacement for any missing teeth you have?___
_____
5. Are you apprehensive or uncomfortable about dental treatment?_____
_____
6. Have you had any periodontal (gum) treatments?_____
_____
7. Do your gums bleed, or feel tender or irritated when you brush? _____
_____
8. Are you having any problems with your teeth? _____
_____
9. Are you unhappy with the appearance of any of your teeth? _____
_____
10. Are you aware of grinding or clenching your teeth? _____
_____
11. Do you have headaches, earaches or neck pains? _____
_____
12. Do you have discolored teeth that bother you? _____
_____
13. Do you regularly use dental floss (daily)? _____
_____
14. How do you feel about keeping your natural teeth for a lifetime? _____
_____