Lifetime Dental

family, cosmetic and implant dentistry

SMILE EVALUATION

Patient Name: ____________________ * ____________________ * ____ ____________________

Last | First | MI | Preferred Name

How often do you visit the dentist? *

◯ Every 6 Months ◯ Every 1-2 Years ◯ In An Emergency

Are you pleased with the appearance of your teeth when you smile? * ◯ Yes ◯ No

Describe your approach to dentistry using the following scale:
1 - I prefer to fix problems while they are small, simple and easy.
5 - I only want to fix something after it is broken or I feel pain. *

◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5

Are your teeth:

☐ Chipped ☐ Sticking Out ☐ Crowded ☐ Spaced (Gaps)

Are you interested in straightening your teeth? * ◯ Yes ◯ No

Are you interested in whitening your teeth? * ◯ Yes ◯ No

Do you have any clicking, popping, discomfort or pain in the jaw? * ◯ Yes ◯ No

Do you clench or grind your teeth? * ◯ Yes ◯ No

Are you interested in dental appliances that help with snoring and sleep apnea? * ◯ Yes ◯ No

Do you have sores or ulcers in your mouth? * ◯ Yes ◯ No

Do your gums bleed when you brush or floss? * ◯ Yes ◯ No

Have you had any periodontal (gum) treatments? * ◯ Yes ◯ No

Have you ever had a serious injury to your head or mouth? * ◯ Yes ◯ No

Is your mouth dry? * ◯ Yes ◯ No

Are your teeth sensitive to cold, hot, sweets or pressure? * ◯ Yes ◯ No

Do you have any dental work you are not happy with? * ◯ Yes ◯ No

Are you currently experiencing dental pain or discomfort? * ◯ Yes ◯ No

Have you had any problems associated with previous dental treatment? * ◯ Yes ◯ No

What would you like to change (if anything) about the appearance of your smile?

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