Smile Analysis

Today's Date_____ Patient Number _____

1. **Do you love the way your smile looks?** ☐ Yes ☐ No

2. **Do you feel comfortable showing your teeth when you laugh or smile?** ☐ Yes ☐ No

3. **If you could change anything about your smile, it would be (check all that apply) :**

   ☐ Color of your teeth ☐ Too much or too little of teeth show when you smile.
   ☐ Gaps between your teeth ☐ Size/Shape of your teeth ☐ Alignment of your teeth
   ☐ Too much or too little gum shows when you smile ☐ Other_____

4. **Do you have (check all that apply) :**
   ☐ Sensitive or receding gums ☐ Worn/Broken/Chipped teeth ☐ Old or discolored fillings.
   ☐ Missing teeth ☐ old crowns that have dark edges at the top ☐ Other _____

5. **In your line of work or lifestyle, do you (check all that apply):**
   ☐ Visit businesses or clients ☐ Travel ☐ Speak publically ☐ Other _____

6. **If you had a smile makeover, do you think you'd feel (check all that apply) :**
   ☐ More confident ☐ More optimistic ☐ Healthier ☐ Just OK
   ☐ No different ☐ Other _____

7. **Do you or someone in your family have issues with any of the following (check all that apply) :**
   ☐ Chronic bad breath ☐ Grinding teeth ☐ Snoring ☐ Other _____