Adair Dentistry

Patient Name: ____________________________   Date: ______________

Smile Evaluation

1. Do you like the overall appearance of your teeth and your smile? Y N

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2. Do you feel your teeth are in good alignment (straight)? Y N
   If no, describe

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3. Do you have spaces between your teeth that you do not like? Y N

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4. Do you like the color of your teeth? Y N
   If no, describe

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5. Do you like the shape of your teeth? Y N
   If no, describe

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6. Do you consider your existing dental work to be unattractive? Y N
   If yes, describe

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7. What would you like to change most about the appearance of your teeth or your smile?

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Are you having any dental problems that require immediate attention?______________________________
Do any of the following cause tooth discomfort? Hot ___ Cold ___ Sweets ___ Chewing ___
Do your gums bleed while brushing? _____ Do your gums ever feel tender or swollen? ____
Do you clench or grind your teeth? ___ Do your jaws ever feel tired/ache? ___ Click/pop? ___
Do you have frequent headaches? ___ Earaches? ___ Neck or shoulder pain? ___
Can you chew on both sides of your mouth? ___ Comfortably? ___
Do you usually have many cavities? ___ Do you lose fillings or break fillings? ___
Do you have any loose teeth? ___ Cracked or broken teeth?___
Do you have any noticeable wear on your teeth? ___ Food traps? ___
Do you have any missing teeth? ___ Have they been replaced? ___
If so, how? Fixed bridge ___ Removable partial ___ Full denture ___ Dental implant ___
Are you comfortable with the replacement? ___ Please describe

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