Patient Smile Evaluation

Last Name: ______________________

First Name: ______________________

Date: ____/____/_____

1. **Do you like your smile?** **YES** **NO**

   If not, what would you change? ______________________________________

2. **Are you concerned about the shape, spacing or position of your teeth?**
   YES **NO**

3. **Do you snore or suffer from Sleep Apnea?** **YES** **NO**

4. **Do you like the appearance of your silver fillings?** **YES** **NO**

5. **Are you concerned with the whiteness of your teeth?** **YES** **NO**

6. **Have you ever considered braces but did not like their appearance?**
   YES **NO**

7. **Are you missing any teeth?** **YES** **NO**

8. **If you wear dentures, are they loose or painful?** **YES** **NO**

9. **Do you wake up with your jaw in discomfort or clench during the day?**

   YES **NO**

10. **Do you suffer from bleeding gums or bad breath?** **YES** **NO**