

SMILE ANALYSIS

Name: _____

Date: _____

When you see your smile in the mirror, do you like the way your teeth look? YES NO

Is there something about your smile you would like to change? YES NO

Do you have:

discolored teeth? YES NO

chipped or worn edges? YES NO

spaces or gaps between your teeth? YES NO

crooked teeth? YES NO

to much gum showing? YES NO

dark/ silver fillings? YES NO

caps or crowns you are unhappy with? YES NO

any other concerns/ complaints? YES NO

Would you like to whiten your teeth? YES NO

Have you ever seen teeth TOO white? YES NO

Do you have habits that might discolor your teeth? YES NO

Describe: _____

Do you clench or grind your teeth? YES NO

Do you ever get an unpleasant taste in your mouth or coating on your tongue? YES NO

Do you rely on gums, mints or gel strips during the day? YES NO

Do you notice an unpleasant odor on your dental floss? YES NO