Smile Health Self-Assessment

It is our goal to offer dental solutions that align with what is most important to you. Your smile is an important aspect of your appearance and how you present yourself. The questions below will help us identify and address you areas of concern.

Please answer the following questions:

1. Do you like the way your teeth look? ..... YES NO
2. Do you ever have difficulty eating, chewing or drinking? ..... YES NO
3. Do you have teeth that are crooked, misaligned, crowded, or uneven? ..... YES NO
4. Do you have difficulty flossing you teeth due to crowding? ..... YES NO
5. Do you have gaps / spaces between your teeth that you would like closed? ..... YES NO
6. Would you like your teeth to be straighter? ..... YES NO
7. Are the edges of your teeth chipped, or worn down? ..... YES NO
8. Are your gums red, sore, puffy, bleeding or receding? ..... YES NO
9. Have you had previous orthodontic treatment? ..... YES NO
10. Have you noticed your teeth shifting or moving? ..... YES NO
11. Are you self-conscious about your teeth or avoid showing your teeth when smiling? ..... YES NO
12. Do you snore? ..... YES NO
13. Have you ever been diagnosed with Sleep Apnea? ..... YES NO
14. Rate your smile on a scale of 1-10 (10 being very happy) 1 2 3 4 5 6 7 8 9 10
15. If you could change anything about your smile what would it be? _____

_____

_____

16. What has stopped you from getting these issues addressed in the past? Cost / Convenience / Time / Other

_____

17. If we could help fix any or all of these concerns you listed would you like to learn more? ..... YES NO
18. Have you ever considered invisible clear aligner or other forms of orthodontic therapy? ..... YES NO

Please share any other concerns you may have about the esthetics's or functionality of you smile.

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Patient Name: _____ Date: _____

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