GEARIN
AESTHETIC & GENERAL DENTISTRY

Smile Assessment

Take our survey to see if you might be a candidate for an enhanced smile.

Last dental appointment: _____

Reason for leaving your last dentist: _____

Current dental concern/reason for visit: _____

Yes	No	
❑	❑	Are you missing teeth?
❑	❑	Are your gums receding?
❑	❑	Do your gums bleed when brushing?
❑	❑	Have you noticed any gum swelling around any teeth?
❑	❑	Does food catch between your teeth?
❑	❑	Do you avoid any part of the mouth while brushing?
❑	❑	Do you smoke/use chewing tobacco?
❑	❑	Are your gums or teeth sensitive? ❑ Heat ❑ Cold ❑ Sweets ❑ Biting Pressure
❑	❑	Do you have an unpleasant taste or odor in your mouth?
❑	❑	Do you have any jaw problems: ❑ Jaw clicking/popping ❑ Pain (joints, ears, side of face) ❑ Difficulty opening or closing ❑ Difficulty chewing
❑	❑	Do you clench or grind your teeth?
❑	❑	Do you have unsightly crowns or fillings?
❑	❑	Do you have difficulty sleeping or have you been diagnosed with sleep apnea?
❑	❑	Do you snore?
❑	❑	Are you dissatisfied with the appearance of your teeth? Explain (too long, too short, color, etc.): _____
		_____
❑	❑	Would you like to improve the whiteness/brightness of your teeth?
❑	❑	Are you interested in improving the alignment of your teeth?
❑	❑	Are you anxious or fearful of dental treatment?
❑	❑	Is lack of time holding you back from a perfect smile?
❑	❑	Are you deeply concerned about the financial cost to help you achieve a perfect smile?

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