Smile & Oral Health Evaluation

Thank you in advance for allowing our dental team the opportunity to get to know you better.
Where applicable please rate your responses from 1 to 10. (1 lowest- 10 highest)

Patient Name: _____

Rate how anxious you are about dental treatment?

1 2 3 4 5 6 7 8 9 10

Rate your overall oral health?

1 2 3 4 5 6 7 8 9 10

Rate the appearance of your smile?

1 2 3 4 5 6 7 8 9 10

Rate the color of your teeth?

1 2 3 4 5 6 7 8 9 10

Rate your concern with silver/mercury fillings?

1 2 3 4 5 6 7 8 9 10

Rate the straightness of your teeth?

1 2 3 4 5 6 7 8 9 10

What would you like to improve about your smile? (check all that apply)

__I would like whiter, brighter teeth.

__I would like to get rid of gaps between teeth.

__I would like to repair chipped or broken teeth.

__I would like to replace missing teeth.

__I would like to straighten my teeth.

__I would like to improve my oral health routine.

Signature: _____ Date: _____