Smile Solutions
by Emmi Dental Associates

Smile Analysis (21+)

Patient Name:	Date:

What do you expect from a preventative cleaning? _____

_____

1. On a scale of 1-10 how would you rate your apprehension with dental visits?
   (10 being very apprehensive) 1-2-3-4-5-6-7-8-9-10
2. On a scale of 1-10 how important is it to keep your natural teeth?
   (10 being very important) 1-2-3-4-5-6-7-8-9-10

Yes/No Are you familiar with nitrous gas?
Yes/No Do your gums bleed?
Yes/No Do you feel you have bad breath?
Yes/No Are you familiar with periodontal disease?
Yes/No Do you wish your teeth were whiter?
Yes/No Are you familiar with in-office whitening?
Yes/No Do you like the way your teeth are shaped?
Yes/No Do you use an electric toothbrush, if so what brand/model? _____
Yes/No Are you interested in orthodontics?
Yes/No Are you happy with your smile?
Yes/No Do you wear dentures? What year were they made? _____

- If yes, are you happy with the feel and look of your dentures? Yes/No

Yes/No Did you know the ADA recommends getting new dentures every 5 years?

Is there anything you would like to change about your smile? _____

_____

Additional comments: (staff use only)