Patient Smile Interview Form

Please describe the reason for your consultation today. Are you experiencing any pain or have any specific concerns? ____

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Have you consulted with any other dentist about this? If yes, what was discussed or done?

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If you could change just one thing about your *front teeth*, those we see when you smile: What would that be? ____

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Do you like the color of your front teeth, are they white enough? ___**No** ___**Yes**

Do you like the shape of your teeth? ___**No** ___**Yes**

Do you have spaces in your front teeth that bother you? ___**No** ___**Yes**

Are your teeth too crowded? ___**No** ___**Yes**

Do you see dark restorations in your teeth that bother you when you smile? ___**No** ___ **Yes**

Now let's talk about your *back teeth*, the ones you chew on:

If there was anything you could change about these, what would it be?

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Do you have any sensitivity to hot and cold or when you chew? ___**No** ___**Yes**

Do you have any difficulty chewing? ___**No** ___**Yes**

Are you missing any teeth? ___**No** ___**Yes**

Does food get trapped between your teeth? ___**No** ___**Yes**

Your *gums* aren't something most people think about, but let me ask you this:

Do your gums ever bleed? ___**No** ___**Yes**

Do you ever experience any sensitivity? ___**No** ___**Yes**

Do you have a bad odor or taste in your mouth? ___**No** ___**Yes**

Do you have any recession (receding gums)? ___**No** ___**Yes**

Do you have removable appliances in your mouth? ___**No** ___**Yes**

If **yes**, are they comfortable? ___**No** ___**Yes**

What are your dental priorities and what would you like us to do for you? __________________

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