

Welcome to Our Office

Date _____

Patient's Last Name _____ First Name _____ Initial _____

Address _____ City, State _____ Zip _____

Home Phone _____ Work Phone _____ Fax _____

Cell Phone _____ Email _____ Marital Status S M D W

Date of Birth _____ Social Security No. _____ Drivers License No. _____

Employer _____ Address _____

City, State, Zip _____ Full Time Student, Where? _____

Person to contact in case of emergency _____

Home Phone _____ Work Phone _____ Cell Phone _____

Whom may we thank for referring you to our office? _____



Smile Analysis



Tooth Color

Are your teeth: yes no unsure

too yellow? too brown?

too dark? too uneven color?

too spotted? too discolored?

Do you have unattractive fillings or restorations?

Tooth Shape

Are your teeth unattractively shaped? yes no unsure

Are your teeth: yes no unsure yes no unsure

too square? too rounded?

too irregular in shape? yes no unsure

Gums

Do you show too much gum tissue (gummy smile)? yes no unsure

Are your gums red and/or swollen? yes no unsure

Does the shape of the gums surrounding the teeth appear unattractive? yes no unsure

Is there anything you would like changed about your smile?

Are you satisfied with the color of your teeth? yes no

Are you satisfied with the arrangement of your teeth?

Are you satisfied with your smile?

Are you satisfied with the appearance of your teeth?

Tooth Position

Are your teeth too crowded? yes no unsure

Do your teeth have spaces between them? yes no unsure

If your teeth have spaces between them, how many spaces (circle the correct number) 1 2 3 4 5 6

Tooth Size

Are you teeth: yes no unsure yes no unsure

too long? too short?

too wide? too narrow?

too large? too small?

Are your two upper center front teeth the same length or shorter than the two neighboring teeth?

