Smile Check

☺ Name:_____

ARE YOU EXPERIENCING ANY OF THE FOLLOWING?

- ☐ Sensitivity to hot or cold
- ☐ Sensitivity when biting down
- ☐ Headaches or Earaches☺
- ☐ Neck discomfort
- ☐ Jaw discomfort
- ☐ Broken teeth or fillings
- ☐ Grinding or clenching of teeth
- ☐ Sensitive or bleeding gums
- ☐ Bad breath or taste in the mouth
- ☐ Snoring
- ☐ Daytime tiredness & sleepiness
- ☐ Other_____

IF YOU COULD CHANGE YOUR SMILE, WHAT WOULD YOU LIKE TO DO?

- ☐ Brighten my teeth
- ☐ Straighten my teeth
- ☐ Replace metal fillings with white fillings
- ☐ Replace missing teeth
- ☐ Restore broken teeth or fillings
- ☐ Have a smile makeover
- ☐ Other_____

HOW IMPORTANT IS YOUR SMILE TO YOU? *(please circle)*

Not very				Neutral				Extremely	
1	2	3	4	5	6	7	8	9	10

HOW DO YOU RATE THE OVERALL CONDITION OF YOUR MOUTH? *(please circle)*

1	2	3	4	5	6	7	8	9	10
Poor				Average				Excellent	

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