London Bridge Smiles

A DIVISION OF ATLANTIC DENTAL CARE, P.L.C.

PATIENT NAME: _____ Today's Date: _____

SMILE ASSESSMENT

Tell us how you feel about your smile by rating each aspect of your smile from 1-5 (5 being the highest)

1. How would you rate the SHADE/COLOR of your teeth?	1	2	3	4	5
2. How would you rate the SHAPE of your teeth?	1	2	3	4	5
3. Please rate the ALIGNMENT of you teeth?	1	2	3	4	5
4. Overall, how would you rate your smile?	1	2	3	4	5

Please answer the following questions:

1. Do you feel your teeth are too crowded?	YES	NO
2. Do you have chips/cracks/wear on teeth that you would like to address?	YES	NO

CAN WE ANSWER ANY QUESTIONS YOU HAVE ABOUT:

- ☐ **WHITENING**
- ☐ **VENEERS / LUMINEERS**
- ☐ **COSMETIC SMILE ENHANCEMENT**
- ☐ **ORTHODONTICS (BRACES)**
- ☐ **INVISALIGN (CLEAR TRAY SYSTEM TO STRAIGHTEN TEETH)**
- ☐ **CARE CREDIT- MAKING YOUR TREATMENT MORE AFFORDABLE WITH FINANCING**

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PATIENT NAME: _____ Today's Date: _____

DENTAL QUESTIONAIRE

1. Are you concerned you will not keep your teeth the rest of your life?	Yes or No
2. Are you nervous about having dental treatment?	Yes or No
3. Rate your overall health (10= excellent—1= poor)	10 9 8 7 6 5 4 3 2 1
Why? _____	
4. Rate your overall dental health (10= excellent—1= poor)	10 9 8 7 6 5 4 3 2 1

PATIENTS IN PAIN OR HAVING A PROBLEM TODAY

1. Are your teeth or gums sensitive to:	**HOT**	Yes or No
	COLD	Yes or No
	BITING PRESSURE	Yes or No
2. Do you have pain that lingers for more than a few seconds or wakes you at night?		Yes or No
3. Do your gums bleed when brushing or flossing?		Yes or No
4. Do you have any swelling?		Yes or No
5. Do you have an unpleasant taste or odor in your mouth?		Yes or No
6. Do you have difficulty opening your mouth?		Yes or No
7. Do you have a clicking or popping jaw?		Yes or No
8. Do you grind or clench your teeth?		Yes or No
9. Do you have headaches or sore muscles in your head and neck?		Yes or No