Smile Analysis

Amit Shah, DDS
Creating Healthier Smiles

Today's date _____ **Patient Number** _____

1. Do you love the way your smile looks? ☐ Yes ☐ No

2. Do you feel comfortable showing your teeth when you laugh or smile? ☐ Yes ☐ No

3. If you could change anything about your smile, it would be (check all that apply):

☐ Color of your teeth ☐ Too much or too little of teeth show when you smile ☐ Gaps between your teeth
☐ Size/Shape of your teeth ☐ Too much or too little of gum shows when you smile ☐ Alignment of your teeth
☐ Other: _____

4. Do you have (check all that apply):

☐ Sensitive or receding gums ☐ Worn/broken/chipped teeth ☐ Old or discolored fillings ☐ Missing teeth
☐ Old crowns that have dark edges at the top ☐ Other: _____

5. In your line of work or lifestyle, do you (check all that apply):

☐ Visit businesses or clients ☐ Travel ☐ Speak publicly ☐ Other: _____

6. If you had a smile makeover do you think you'd feel (check all that apply):

☐ More confident ☐ More optimistic ☐ Healthier
☐ Just OK ☐ No different ☐ Other: _____

7. Do you or someone in your family have issues with any of the following (check all that apply):

☐ Chronic bad breath ☐ Grinding teeth ☐ Snoring
☐ Other: _____

We'd like to know more about you so we can better serve you!

8. Do you prefer appointments in the (check all that apply):

☐ Early morning ☐ Early afternoon ☐ No preference
☐ Late morning ☐ Late afternoon ☐ Other: _____

9. Do you have any special dates or upcoming events you'd like us to remember? (weddings, graduations, etc.)

_____
_____
_____

10. What type(s) of music do you enjoy? (check all that apply)

☐ Easy Listening ☐ Classical ☐ Rock ☐ Hip-Hop/Rap
☐ Jazz ☐ Country ☐ R&B ☐ Other:_____

11. What are your favorite hobbies or activities?

_____
_____
_____

12. Do you have children and grandchildren? If so, please list their names and ages.

_____
_____
_____

13. Is there anything else that you want our office to know about you that will help us to serve you better?

_____
_____
_____