

Smile Evaluation

A Simple Evaluation to Help You Obtain the Smile You've Always Wanted

Hold a mirror 12"–14" from your face. Smile to show your teeth. Take the time to observe your teeth carefully, and then answer the following questions:

1 Do you like the appearance of your teeth and your smile? Yes No
If not, explain _____



STAINED AND CHIPPED

2 Are your teeth all in alignment (straight)? Yes No
If not, explain _____



SPACES

3 Do you have spaces that you don't like? Yes No
If yes, explain _____

4 Do you like the color of your teeth? Yes No
If not, explain _____



CALCIFICATION STAINS

5 Do you like the shape of your teeth? Yes No
If not, explain _____



FANGED TEETH

6 Are your teeth...
Chipped Yes No Protruding Yes No Hidden Yes No
If yes, explain _____

7 Are your teeth wearing on the biting surfaces? Yes No
If yes, explain _____



STAINED AND CROOKED TEETH

8 Are there old fillings or dental work you don't like looking at? Yes No
If yes, explain _____



PORCELAIN CROWNS

9 What would you like to change the most in the appearance of your teeth?

10 How would you like your teeth to look?



BEAUTIFUL SMILE

If you are not happy with the appearance of your teeth, ask your dentist how they can improve your smile.

LUMINEERS®

snapon
smile.

duo PCH™
Porcelain Composite Hybrid

Health History

Mr. Mrs. Miss Ms. _____ Birthdate _____ Age _____ Soc. Sec. No. _____
Home address _____ City _____ State _____ Zip _____ Phone _____
Dental Insurance _____ Group or Plan No. _____ Referred By _____
Person financially responsible _____ Relationship to you _____ Soc. Sec. No. _____
Spouse/Partner name _____ Birthdate _____ Employer _____ Soc. Sec. No. _____
Occupation _____ Employer _____ Phone _____
Person to contact in case of emergency _____ Phone _____

Medical History

Physician _____ Address _____ Phone _____

Are you in good health? _____ If no, explain _____

Do you have an existing illness? _____ If yes, explain _____

Have you been hospitalized in the past two years? _____ If yes, explain _____

Do you bleed excessively when cut? _____ Do you smoke? _____ If yes, how much? _____

Are you taking any medication, pills or drugs? _____ If yes, please list: _____

Do you now have, or have you had any of the following? (If yes, describe under remarks.)

	YES	NO		YES	NO
1. Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	14. Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>
2. High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	15. Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>
3. Blood Disease	<input type="checkbox"/>	<input type="checkbox"/>	16. Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
4. Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	17. Asthma	<input type="checkbox"/>	<input type="checkbox"/>
5. Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	18. Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
6. Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	19. AIDS or HIV positive	<input type="checkbox"/>	<input type="checkbox"/>
7. Stroke	<input type="checkbox"/>	<input type="checkbox"/>	20. Allergy to: (a) Penicillin	<input type="checkbox"/>	<input type="checkbox"/>
8. Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	(b) Other Antibiotics	<input type="checkbox"/>	<input type="checkbox"/>
9. Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	(c) Local Anesthetics	<input type="checkbox"/>	<input type="checkbox"/>
10. Tumor History	<input type="checkbox"/>	<input type="checkbox"/>	(d) Other	<input type="checkbox"/>	<input type="checkbox"/>
11. VD	<input type="checkbox"/>	<input type="checkbox"/>	21. Are you pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
12. Nervous Disorders	<input type="checkbox"/>	<input type="checkbox"/>	22. Have you ever used Fen-Phen?	<input type="checkbox"/>	<input type="checkbox"/>
13. Radiation Treatment	<input type="checkbox"/>	<input type="checkbox"/>			

Dental History

Do you have any present dental complaints? Yes No What? _____

When was your last full-mouth X-ray taken? _____ Where? _____

When was your last cleaning? _____ Where? _____

Have you ever been instructed in the prevention of decay? _____

Have you ever been instructed in caring for your gums? _____

Remarks

I consent to whatever dental procedures and anesthetics are necessary for the treatment of the above named patient.

I also agree to assume full financial responsibility for all treatment rendered.

Signature _____ Date _____