

# DENTAL ASSESSMENT

On a scale of 1-10, 10 being the best, where would you rate your oral health? \_\_\_\_\_

On a scale of 1-10, 10 being the best, where would you rate your smile? \_\_\_\_\_

Is the brightness of your teeth important to you? [Y] [N]

If you could change anything about your smile, and or facial appearance, which of the following would you want? Please circle [Y] or [N]:

Whiter teeth	[Y] [N]	Close space or spaces	[Y] [N]
Replace chipped teeth	[Y] [N]	Remove mercury silver fillings	[Y] [N]
Less Gum showing	[Y] [N]	Straighter	[Y] [N]
Replace missing teeth	[Y] [N]	Replace old crowns	[Y] [N]
Remove Stains/Spots on teeth	[Y] [N]	Reshape/resize my teeth	[Y] [N]
Replace old plastic fillings	[Y] [N]	More youthful appearance	[Y] [N]
Botox (Reduce wrinkles)	[Y] [N]	Juvederm (folds in face)	[Y] [N]

Does having dental treatment make you afraid or nervous? [Y] [N]

Do any of the following items bother you?

Bad Breath [Y] [N]

Dry Mouth [Y] [N]

Snoring [Y] [N]

Please circle the following which are important to you when making you dental health decision:

Convenience	Appearance	Relationship with Dental Team
Finances	Time	Quality of Care
What insurance covers	Health	Detailed treatment explanations
Fear or Anxiety	Comfort	Technology