

DENTAL HEALTH EVALUATION

Name: _____

Date: _____

- 1.) Are you pleased with the appearance of your teeth?
- 2.) Do you have any broken or missing teeth?
- 3.) Are your teeth as white as you would like them to be?
- 4.) Are your teeth as straight as you would like them to be?
- 5.) Are your teeth shifting or becoming more crowded?
- 6.) Do you pack food between any teeth while chewing?
- 7.) Are your teeth sensitive to hot? To cold? To chewing?
- 8.) Are you aware of any problems with your gums?
- 9.) Are your gums sore or do they bleed when you brush/ floss?
- 10.) Is there anything about your smile you would like to change?
- 11.) Are you concerned about offensive breath odor?
- 12.) What are your chief concerns for your dental health?

Signature: _____

If you have any questions or comments about any dental procedures, practice policies, or a personal concerns relating to your dental health, please feel free to speak with any of our highly trained staff. We will take the time to listen to your concerns and do everything possible to ensure your visits to our office are pleasant and effective.