goldstein, garber & salama, llc
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Personalized Smile Evaluation

Name: _____ Age: ____ Today's Date: _____

Hold a full face mirror about 12 inches from your face. Smile to show your teeth. Take the time to observe your teeth and gums carefully. Then answer the following questions. Your answers will allow us to design a smile improvement plan to help you obtain the smile you've always wanted.

1. Do you like the appearance of your teeth or your overall smile? Yes ☐ No ☐ If not, why not?
   _____
   _____

2. Do you have spaces between your teeth that bother you? Yes ☐ No ☐ Are these spaces changing? Yes ☐ No ☐ If yes, any comments?
   _____
   _____

3. If your teeth are crooked or crowded, does that bother you? Yes ☐ No ☐ If yes, any comments?
   _____
   _____

4. Do you feel that your teeth are protruding? Yes ☐ No ☐ If yes, any comments?
   _____
   _____

5. Do you like the color of your teeth? Yes ☐ No ☐ If not, why not?
   _____

6. Do you like the size and shape of your teeth? Yes ☐ No ☐ If not, why not?
   _____

7. Have you ever had periodontal care? Yes ☐ No ☐ Orthodontic care? Yes ☐ No ☐

8. How many times have you had your teeth cleaned in the last five years? _____ When was the last time? _____

9. Are you aware of clenching or grinding your teeth? Yes ☐ No ☐ Do you wear a nightguard? Yes ☐ No ☐

10. Have you ever had a bad experience in the dental office? Yes ☐ No ☐ If so, please explain:
    _____
    _____
    _____
11. Is there anything that concerns you about cosmetic treatment of the teeth or gums? Yes ☐ No ☐ What? _____
12. Do you show too much gum when you smile? Yes ☐ No ☐ Does it bother you? Yes ☐ No ☐
13. Are you aware of any gum or bone disease in your mouth? Yes ☐ No ☐ Does it bother you?
14. Did any of your relatives lose their teeth due to gum or bone disease? Yes ☐ No ☐ Who?
    _____
15. Have you ever experienced any of the following?

___ bleeding gums	___ pus around the teeth	___ foul odor
___swelling gums	___ loose teeth	___bad breath or bad taste
___pain or soreness	___spaces between teeth	___ food packing
___ receding gums	___drifting of teeth	___ high or rough fillings

16. Do you have gum recession? Yes ☐ No ☐ Is it changing? Yes ☐ No ☐ Where?
    _____
17. If you smile was improved, would you feel more confident? Yes ☐ No ☐ If yes, how?
    _____
    _____
18. What would you like to change about the appearance of your teeth and smile?
    _____
    _____
19. In general, how do you feel about your smile? _____
    _____
20. Overall, how would you like your teeth to look? _____
    _____

Signature: _____