It is a main concern of our office to not only escort you to complete oral health, but also to understand your concerns and desires regarding your appearance. Please take a moment to fill out our quick survey to evaluate how you feel of one of your greatest assets, your smile.

Who may we thank for referring you to our practice? _____

Are you currently experiencing any pain or discomfort?

_____

_____

If you could change just one thing about your <u>front teeth</u>, those we see when you smile:
What would that be?

_____

_____

How do you feel about the color of your front teeth, are they white enough? ❑ No ❑ Yes

Do you like the way they are shaped? ❑ No ❑ Yes
Are your front teeth as straight as you'd like them to be? ❑ No ❑ Yes
Are you satisfied with their overall appearance? ❑ No ❑ Yes
Is there anything you'd like to change about them? ❑ No ❑ Yes

Now let's talk about your <u>back teeth</u>, the ones you chew on:

If there was anything you could change about these,
what would it be? _____

Do you have any sensitivity to hot or cold or when you chew? ❑ No ❑ Yes
Do you have any difficulty chewing? ❑ No ❑ Yes
Are you missing any teeth? ❑ No ❑ Yes
Does food get trapped and annoy you? ❑ No ❑ Yes
Is there anything in the back that you'd like us to look at? ❑ No ❑ Yes

_____

_____

Your <u>gums</u> aren't something most people think about, but let me ask you this:

Do your gums ever bleed? ❑ No ❑ Yes
Do you ever experience any sensitivity? ❑ No ❑ Yes
How is your breath? _____
Do you have any gum recession? ❑ No ❑ Yes

_____

_____

Do you have removable pieces in your mouth? ❑ No ❑ Yes
Are they comfortable? ❑ No ❑ Yes

_____