

# SMILE EVALUATION

## Dr. Hugo E. Artaza, D.D.S

NAME:

DATE:

Is there anything about your smile you don't like?

Do you like the appearance of your teeth?

Are your teeth all in alignment (straight)?

Do you have any missing teeth?

Are any chipped?

Is your bite comfortable for chewing, biting?

Do you have frequent headaches?

Do you have any old fillings or dental work that you don't like?

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

Are you aware of the new techniques in dentistry?

If money were no object, what improvements would you make to your smile?

### *DENTAL HISTORY*

Are you nervous about dental treatment?

Is there anything about your mouth that concerns you now?

What type of toothbrush do you use? Soft  Medium  Hard

Do you use dental floss? Toothpicks? How often?

Do your gums ever bleed?

Are any of your teeth mobile (loose)?

Do you have any swelling, sores, or blisters in your mouth?

Have you ever been instructed in how to prevent tooth decay?

Have you ever been told that you have gum disease?

Do you smoke?

Chew Tobacco?

Do you feel you have unpleasant breath at times?

How would you describe your dental health?

### *REMARKS*