Smile Evaluation Form

Dr. Sherri Scott would like to help you obtain the smile you've always wanted. Please take a few minutes to complete this short questionnaire.

1. What is the "main" reason for this appointment today? ________________________________
   ____

2. Are you interested in comprehensive care for current conditions?____yes ______no

3. Are you interested in regular care to maintain long-term dental health? _____yes _____no

4. Do you tend to Clinch or Grind your teeth? _____yes _____no

5. Do you like the appearance of your teeth and your smile? ____yes ____no
   If not, explain: ____
   ____

6. Are you pleased with the alignment of your teeth? ____yes ____ no
   Are your teeth crowded and hard to floss? ____yes ____no

   If not, explain: ____
   ____

7. Do you have spaces that collect food? ____yes ____no

8. Do you like the color of your teeth? ____yes ____no
   If not, would you be interested in our fast, easy and inexpensive teeth whitening?
   ____yes ____no

9. Are there old fillings or dental work that you are concerned with? ____yes ____no
   If yes, explain: ____
   ____

10. Do you have any pain other concerns regarding your smile/teeth?
   ____
   ____

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