

Take our...

SMILE ASSESSMENT

Name _____ Date _____

Yes No

- Are you comfortable showing your teeth when you smile?
- Are you happy with the appearance of your teeth?
- Do you have unsightly crowns or fillings?
- Can you eat hot or cold foods without experiencing tooth sensitivity?
- Are you happy with the length of your teeth (neither too long nor too short)?
- Do you like the color of your teeth?
- Do you have a complete smile (28 or more teeth)?
- Are you interested in improving the appearance of your teeth?
- Are you familiar with the benefits of dental implants?
- Are your gums healthy (not receding, bleeding or swollen)?
- Are you happy with the alignment of your teeth?
- Are you anxious or fearful of treatment?

Please list any additional comments or concerns:



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