Smile Evaluation

A Simple Evaluation to Help You Obtain the Smile You've Always Wanted

Hold a mirror 12"–14" from your face. Smile to show your teeth. Take the time to observe your teeth carefully, and then answer the following questions:

1 Do you like the appearance of your teeth and your smile? □**Yes** □ **No**
If not, explain _____
_____

2 Are your teeth all in alignment (straight)? □ **Yes** □ **No**
If not, explain _____
_____

3 Do you have spaces that you don't like? □ **Yes** □ **No**
If yes, explain _____
_____

4 Do you like the color of your teeth? □ **Yes** □ **No**
If not, explain _____
_____

5 Do you like the shape of your teeth? □ **Yes** □ **No**
If not, explain _____
_____

6 Are your teeth…
Chipped □ **Yes** □ **No** Protruding □ **Yes** □ **No** Hidden □ **Yes** □ **No**
If yes, explain _____
_____

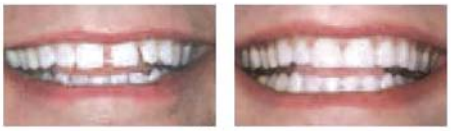
7 Are your teeth wearing on the biting surfaces? □ **Yes** □ **No**
If yes, explain _____
_____

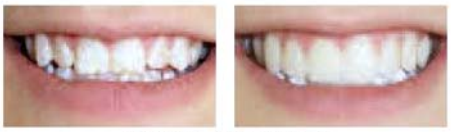
8 Are there old fillings or dental work you don't like looking at? □ **Yes** □ **No**
If yes, explain _____
_____

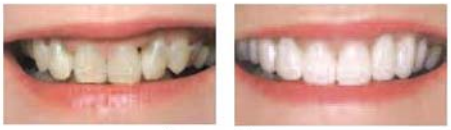
9 What would you like to change the most in the appearance of your teeth?
_____
_____

10 How would you like your teeth to look?
_____
_____


STAINED AND CHIPPED


SPACES


CALCIFICATION STAINS


FANGED TEETH


STAINED AND CROOKED TEETH


PORCELAIN CROWNS


BEAUTIFUL SMILE

If you are not happy with the appearance of your teeth, ask your dentist how they can improve your smile.

LUMINEERS®

snap on smile™

duo PCH™ Porcelain Composite Hybrid

Health History

Mr. Mrs. Miss Ms. _____Birthdate_____Age_____Soc. Sec. No._____

Home address_____City_____State_____Zip_____ Phone_____

Dental Insurance_____Group or Plan No._____Referred By_____

Person financially responsible_____Relationship to you_____ Soc. Sec. No._____

Spouse/Partner name_____Birthdate_____Employer_____ Soc. Sec. No._____

Occupation_____Employer_____ Phone_____

Person to contact in case of emergency_____Phone_____

Medical History

Physician_____Address_____ Phone_____

Are you in good health?_____If no, explain_____

Do you have an existing illness?_____If yes, explain_____

Have you been hospitalized in the past two years?_____If yes, explain_____

Do you bleed excessively when cut?_____Do you smoke?_____If yes, how much?_____

Are you taking any medication, pills or drugs?_____If yes, please list:_____

Do you now have, or have you had any of the following? (If yes, describe under remarks.)

		YES	NO				YES	NO
1.	Heart Disease	❑	❑	14.	Liver Disease		❑	❑
2.	High Blood Pressure	❑	❑	15.	Kidney Disease		❑	❑
3.	Blood Disease	❑	❑	16.	Hepatitis		❑	❑
4.	Rheumatic Fever	❑	❑	17.	Asthma		❑	❑
5.	Heart Murmur	❑	❑	18.	Tuberculosis		❑	❑
6.	Diabetes	❑	❑	19.	AIDS or HIV positive		❑	❑
7.	Stroke	❑	❑	20.	Allergy to:	(a) Penicillin	❑	❑
8.	Epilepsy	❑	❑			(b) Other Antibiotics	❑	❑
9.	Arthritis	❑	❑			(c) Local Anesthetics	❑	❑
10.	Tumor History	❑	❑			(d) Other	❑	❑
11.	VD	❑	❑	21.	Are you pregnant?		❑	❑
12.	Nervous Disorders	❑	❑	22.	Have you ever used Fen-Phen?		❑	❑
13.	Radiation Treatment	❑	❑					

Dental History

Do you have any present dental complaints? ❑ Yes ❑ No What?_____

When was your last full-mouth X-ray taken?_____Where?_____

When was your last cleaning?_____ Where?_____

Have you ever been instructed in the prevention of decay?_____

Have you ever been instructed in caring for your gums?_____

Remarks

_____

_____

I consent to whatever dental procedures and anesthetics are necessary for the treatment of the above named patient.

I also agree to assume full financial responsibility for all treatment rendered.

Signature_____ Date_____