

# Dallas Laser Dentistry

## SMILE ANALYSIS

Name: \_\_\_\_\_

Date: \_\_\_\_\_

How often do you have your teeth cleaned? \_\_\_\_\_

How often do you brush your teeth? \_\_\_\_\_

How often do you floss your teeth? \_\_\_\_\_

Do you grind or clench your teeth? Y/N/DK

Do you bite your fingernails? Y/N/DK

Do you chew on pens or pencils? Y/N/DK

Do you smoke? Y/N/DK

Do you drink coffee or hot tea? Y/N/DK

If so, how many combined cups per day? \_\_\_\_\_

Do you drink iced tea or colas? Y/N/DK

If so, how many per day? \_\_\_\_\_

When you look in the mirror, do you like the appearance of your teeth? Y/N/DK

Do you like the length of your teeth? Y/N/DK

Do you like the shape of your teeth? Y/N/DK

Do you have any stained teeth? Y/N/DK

Do you like the color of your teeth? Y/N/DK

Would you like your smile to look 10 years younger? Y/N/DK

Do you have any spaces between your teeth? Y/N/DK

Do you have any teeth with white spots? Y/N/DK

Do you have any chips or cracks in your teeth? Y/N/DK

Do you have any crooked teeth? Y/N/DK

Are you missing any teeth? Y/N/DK

If so, would you like to have the missing teeth replaced? Y/N/DK

Do you have any silver fillings you'd eventually like replaced with tooth-colored ones? Y/N/DK

Do you have any teeth you believe need caps or bonded porcelain inlays? Y/N/DK

Do you have any caps that have metal showing through, or are unattractive to you? Y/N/DK

Have you had braces in the past? Y/N/DK

If yes, were you pleased with the results? Y/N/DK

If yes, have you continued to wear your retainer, at least at nighttime? Y/N/DK

Have you ever had or considered any cosmetic surgery? Y/N/DK

**Would you like to see what you would look like with a great looking smile? Y/N/DK**

**Mary Swift DDS, P.A.**

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