Apex Dental

1207 Bruce B. Downs Blvd., Wesley Chapel Florida 33543

Smile Analysis

Name____

When was your last dental visit? _______ What was done at that time? ______________________
Yes No Were x-rays taken? When was your last professional cleaning? _______
How do you feel about dental visits? Relaxed Anxious Neutral
On a scale 1- 5 (5 being highest) what priority do you give to your teeth? ____________________
How often do you brush your teeth? ________ How often do you floss your teeth? ______

Yes No Do your gums bleed while brushing or flossing?
Yes No Do you have bad breath?
Yes No Have you noticed any change in the appearance of your face?
Yes No Have you noticed any change in the color of your teeth or gums?
Yes No Do you have any sores, lumps, or swelling in or near your mouth?
Yes No Does too much gum tissue show when you smile?
Yes No Do you have any areas where your gums have receded?
Yes No Have you ever had periodontal (gum) treatment in the past?
Yes No Are your teeth sensitive to sweet or sour liquids/ foods?
Yes No Are your teeth sensitive to hot or cold liquids/ foods?
Yes No Do you notice popping in your jaw?
Yes No Have you had any head, neck or jaw injuries?
Yes No Do you feel pain to any of your teeth?
Yes No Do you clench or grind your teeth?
Yes No Do you like the color of your teeth?
Yes No Do you use tobacco?
Yes No Do you drink coffee, tea or colas? If yes, how many cups per day? ______
Yes No Do you like the shape of your teeth?
Yes No Have you noticed any spaces between your teeth?
Yes No Have you had orthodontic treatment (braces) in the past?
Yes No Have you had any teeth removed?
Yes No If yes, would you like to have the missing teeth replaced?
Yes No Have they ever been replaced by fixed bridge___ partial ___ denture ___ implants
Yes No Have you ever had any difficult extractions in the past?
Yes No Have you ever had prolonged bleeding following extractions?
Yes No Do you have any crooked teeth?
Yes No Do you have any chips or cracks in your teeth?
Yes No Would you like to replace your silver fillings with tooth-colored fillings?
Yes No Do you have any teeth that you believe need caps?
Yes No Do you have any caps that are unattractive or have metal showing through?
Yes No Have you experienced any unfavorable reaction from any dental treatment?
Yes No When you look in the mirror, do you like the appearance of your teeth?
Yes No Would you like to have a great looking smile?

Signed ____ Date ____/ ____/ ____
Signature of Patient (Parent, or Guardian if Minor)