



DENTAL SMILE ANALYSIS

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Your smile affects your self-image, and can greatly influence the quality of your interactions with others. Many people hold back from laughing or smiling because they are uncomfortable with their smile. The following questions are designed to honestly appraise your smile. Go to a mirror, smile as wide as you can, and ask yourself the following questions:

Are any of your teeth yellow, stained or somewhat discolored? YES NO

Would you like your teeth to be whiter? YES NO

Do you have any gaps or spaces between your teeth? YES NO

Are any of your teeth turned, crooked, or uneven? YES NO

Are you missing any teeth? YES NO

Do you see any pitting or defects on the surfaces of your teeth? YES NO

Are the edges of any teeth worn down, chipped or uneven? YES NO

Do any of your teeth appear too small, short, large or long? YES NO

Do you have any prior dental work that appears unnatural? YES NO

Do you have any crowns or bridges that appear dark at the edge of your gums? YES NO

Do you have any gray, black or silver (mercury) fillings in your teeth? YES NO

Do you have a "gummy" smile (too much of your gums show when smiling)? YES NO

Are your gums red, sore, puffy, bleeding or receded? YES NO

Does the appearance of your smile inhibit you from laughing or smiling? YES NO

When being photographed, do you smile with your lips closed YES NO

instead of flashing a full smile? YES NO

Are you self-conscious about your teeth or smile? YES NO

Would you like to change anything about the appearance of your teeth or smile? YES NO

Authorization

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by Dr. Liebes to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform Dr. Liebes.

I authorize my insurance company to pay Dr. Liebes, D.D.S. all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize Dr. Liebes, D.D.S. to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charged whether or not paid by insurance.

Signature: _____ Date: _____