SMILES INTERNATIONAL
Premier Cosmetic & Implant Dentistry

Gary G. Kaihara, D.D.S.
Benjamin O. Watkins, III, D.D.S.

2440 M Street, NW, Suite 610
Washington, DC 20037
P (202) 466-3333
F (202) 466-4155

6845 Elm Street, Suite 475
McLean, VA 22101
P (703)356-3556
F (703)356-3804

PERSONALIZED SMILE EVALUATION

Name:_____ **Age:** _____ **Today's Date:** _____

Hold a full face mirror about 12 inches from your face. Smile to show your teeth. Take the time to observe your teeth and gums carefully. Then answer the following questions. Your answers will allow us to design a smile improvement plan to help you obtain the smile you've always wanted.

1. Do you like the appearance of your teeth or your overall smile? Yes ☐ No ☐ If not, why not?
_____

2. Do you have spaces between your teeth that bother you? Yes ☐ No ☐
Are these spaces changing? Yes ☐ No ☐ If yes, any comments?
_____

3. If your teeth are crooked or crowded, does that bother you? Yes ☐ No ☐ If yes, any comments?
_____

4. Do you feel that your teeth are protruding? Yes ☐ No☐ If yes, any comments?
_____

5. Do you like the color of your teeth? Yes ☐ No ☐ If not, why not?
_____

6. Do you like the size and shape of your teeth? Yes ☐ No ☐ If not, why not?
_____

7. Have you ever had periodontal care? Yes ☐ No ☐ Orthodontic care? Yes ☐ No ☐

8. How many times have you had your teeth cleaned in the last five years? _____
When was the last time? _____

9. Are you aware of clenching or grinding your teeth? Yes ☐ No ☐
Do you wear a nightguard? Yes ☐ No ☐

10. Have you ever had a bad experience in the dental office? Yes ☐ No ☐ If yes, please explain:

_____

_____

11. Is there anything that concerns you about cosmetic treatment of the teeth or gums?

Yes ☐ No ☐ If yes, what? _____

12. Do you show too much gum when you smile? Yes ☐ No ☐

Does it bother you? Yes ☐ No ☐

13. Are you aware of any gum or bone disease in your mouth? Yes ☐ No ☐

Does it bother you? Yes ☐ No ☐

14. Did any of your relatives lose their teeth due to gum or bone disease? Yes ☐ No ☐
If yes, who? _____

15. Have you ever experienced any of the following?

☐bleeding gums	☐pus around the teeth	☐ foul odor
☐swelling gums	☐ loose teeth	☐ bad breath or bad taste
☐pain or soreness	☐spaces between teeth	☐ food packing
☐receding gums	☐drifting of teeth	☐ high or rough fillings

16. Do you have gum recession? Yes ☐ No ☐ If so, is it changing? Yes ☐ No ☐
If yes, where?_____

17. If you smile was improved, would you feel more confident? Yes ☐ No ☐ If yes, how?

_____

18. What would you like to change about the appearance of your teeth and smile?

_____

_____

_____

19. In general, how do you feel about your smile?

_____

_____

_____

20. Overall, how would you like your teeth to look?

_____

_____

_____

Patient Signature: _____