610 Islington Street, Portsmouth, NH 03801

(603)436-7810, harveydentaldiagnostics@gmail.com

SMILE ASSESSMENT

Yes	No	
____	____	Are you comfortable showing your teeth when you smile?
____	____	Are you happy with the appearance of your teeth?
____	____	Do you have unsightly crowns or fillings?
____	____	Are your gums or teeth sensitive?
____	____	Do you feel your teeth are too long?
____	____	Do you feel your teeth are too short?
____	____	Do you like the color of your teeth?
____	____	Are you missing any teeth?
____	____	Are you interested in improving the appearance of your teeth?
____	____	Are you familiar with the benefits of dental implants?
____	____	Are your gums receding?
____	____	Are you anxious or fearful or treatment?
____	____	Are you happy with the alignment of your teeth?
____	____	Is fear holding you back from a perfect smile?
____	____	Is lack of time holding you back from a perfect smile?
____	____	Is cost holding you back from a perfect smile?
____	____	Is there something else holding you back from a perfect smile?

If so, what is holding you back? ______________________________

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Please feel free to explain any answers.

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