Form A

Smile Assessment Questionnaire

Dr. Timothy Brooks

1. What is your reason for the appointment?

2. How long ago was your last dental visit?
3. If there was anything that you could change about your smile, what would it be?

4. Are your teeth sensitive to cold air, ice water, sweets or brushing? Y or N
5. Do you have any sensitive, tender, or swollen gums? Y or N
6. Do you have any sores or lumps in or near your mouth? Y or N
7. Is your breath as fresh as it can be? Y or N
8. Have you ever seen a Periodontist? Y or N
   If yes, please explain.

9. Are you aware if you are clenching or grinding your teeth? Y or N
10. Do you have frequent headaches? Y or N
11. Have you had any head or neck injuries? Y or N
    If yes, please explain

12. Do you require antibiotics before dental treatment? Y or N
13. Do you feel anxious or nervous about having dental treatment? Y or N
14. What do you like most about your last dentist?

15. What do you like least about your last dentist?