**LeGrand Bingham DMD**

**SMILE ASSESSMENT**

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Tell us how you feel about your smile by rating each aspect of your smile from 1-5.**

1. How would you rate the SHADE of your teeth? 1 2 3 4 5

**Where would you like the SHADE of your teeth? 1 2 3 4 5**

1. How would you rate the SHAPE of your teeth? 1 2 3 4 5

**Where would you like the SHAPE of your teeth? 1 2 3 4 5**

1. Please rate the alignment of your teeth. 1 2 3 4 5

**Where would you like the alignment of your teeth? 1 2 3 4 5**

1. Overall, how would you rate your smile? 1 2 3 4 5

**Where would you like your smile to be? 1 2 3 4 5**

**Please answer the following questions:**

1. Do you feel your teeth are too crowded? YES NO
2. Have you felt sensitivity to hot or cold in the last 3 months? YES NO
3. Do you have chips/cracks on teeth that you would like to address? YES NO
4. Do you experience bleeding when you brush your teeth or floss? YES NO

**Please add any additional information you feel is important about your smile and overall oral health.**

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