MELISSA E. RINCK D.D.S.
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(415) 479-4977

SMILE ANALYSIS

NAME: _____

DATE: _____

~When you see your smile in the mirror, do you like the way your teeth look? ☐ *YES* ☐ *NO*

~If you had a magic wand, is there something about your smile you would change? ☐ *YES* ☐ *NO*

~Please describe how you would like your teeth to look.

_____

_____

~Do you have any black mercury fillings that show, or concern you, that you would like changed? ☐ *YES* ☐ *NO*

~Would you like to easily whiten your teeth? ☐ *YES* ☐ *NO*

~Do you have any old crowns or caps that don't match your natural teeth or you are unhappy about? ☐ *YES* ☐ *NO*

~Do you clench or grind your teeth? ☐ *YES* ☐ *NO*

~Are you interested in information about halitosis or bad breath? ☐ *YES* ☐ *NO*

★ ★

Dental Information

Do your gums bleed when your brush? Yes__ No__

Are your teeth sensitive to heat or cold? Yes__ No__ Pressure Yes__ No__ Sweets Yes__ No__

Do you have any fear of dental work? Yes__ No__

Date of last dental visit _____ What was done at the time? _____

Former Dentist's Name _____ City _____

How would you describe your current dental problem? _____

How do you feel about the appearance of your teeth? _____