Smile Evaluation

The Smile You've Always Wanted

Patient name: ______________________________

Date: ______________________________

1. On a scale of 1-10, how would you rate your smile?

Circle 1 2 3 4 5 6 7 8 9 10

2. What changes would you make to improve your smile?

☐ Straight teeth ☐ Whiter teeth ☐ Replace broken/missing teeth

3. How would you feel if you had your ideal smile?

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4. Have you had Orthodontic (teeth straightening) treatment in the past?

☐ Yes ☐ No

5. Would you like to have treatment to improve your smile?

☐ Yes ☐ No

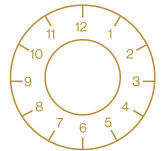
6. How soon would like you like to start treatment to improve your smile?

☐ Immediately ☐ 1-3 months ☐ 3-6 months ☐ 6-12 months

Hygiene Ortho Exam

Patient name: ______________________________

Date: ______________________________

Malocclusion classification: circle				
Molar Relationship	Class I	Class Ii	Class Iii	
Deep Bite	Mild	Moderate	Severe	
Overjet	Mild	Moderate	Severe	Under Bite
Crowding	Mild	Moderate	Severe	
Spacing	Mild	Moderate	Severe	
Crossbite	Anterior	Posterior	Left Side	Right Side
Arch Form	U-Shaped (Rounded)	V-Shaped (Narrow)	Omega (Irregular)	Square (Box)
Lingual Inclination	Mild 5-15 Degrees TOOTH#:	Moderate 15-30 Degrees TOOTH#:	Severe 30-60+ Degrees TOOTH#:	

Associated with improper tooth alignment: tick

- ☐ Receding gums/clefting
- ☐ Abfractions (notching at gum-line)
- ☐ Excessive wearing of teeth
- ☐ Periodontal pocketing
- ☐ Difficulty brushing and flossing increased plaque levels
- ☐ Decay
- ☐ Teeth shifting (crowded)
- ☐ Difficulty eating (food impaction)
- ☐ Gingivitis

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