inspire DENTAL GROUP

Your Smile…Our Inspiration

Name:_____ **Date Of Birth:**_____

To help with your dental concerns, please check YES or NO to the following questions:

1. When was your last dental visit? _____

   Were any x-rays taken at that visit? ❑ **YES** ❑ **NO**

2. Are you happy with the appearance of your teeth? ❑ **YES** ❑ **NO**

3. Do any of the following apply to you?

❑ Jaw Aches	❑ Sensitivity
❑ Ear aches	❑ broken teeth
❑ Dry mouth/bad breath	❑ Bleeding gums/receding gums
❑ Chipped and/or fillings that have chipped or broken	❑ Do you clench or Grind your teeth

   If any of the above concerns apply: please briefly explain:

   _____

4. Do you have any previous dental treatment that is no longer satisfactory? ❑ **YES** ❑ **NO**

5. Do you have a family history of periodontal disease? ❑ **YES** ❑ **NO**

6. Would you be interested in hearing options regarding teeth whitening? ❑ **YES** ❑ **NO**

7. Would you like to improve your existing smile? ❑ **YES** ❑ **NO**

   If so: what is your biggest concern? _____

   _____

Thank you for taking the time to complete your smile assessment!