

# Smile Questionnaire

Patients Name: \_\_\_\_\_ Date: \_\_\_\_\_

When did you last visit a dentist? \_\_\_\_\_

**Do you experience any of the following?**

- Sensitivity (hot/cold/sweet)
- Tooth pain or discomfort when chewing
- Headaches
- Bleeding/Swollen/Irritated gums
- Loose or shifting teeth
- Do you grind or clench your teeth
- Are you concerned about freshness of breath

**Do you have or have you had any of the following?**

- Dentures
- Braces
- Periodontal (gum) treatment
- Veneers
- Tooth Whitening

Would you like to have whiter teeth?

At LS1dental we also offer facial line softening treatments (non-surgical wrinkle reduction)

Would you like further information?

**If I could change my teeth I would:**

- Make them straighter
- Close spaces
- Replace fillings with natural tooth coloured fillings
- Repair chipped teeth
- Replace missing teeth
- Replace old crowns
- Have a smile makeover

Please describe your main dental concern?

---

---

---

---