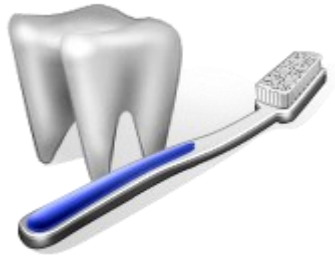
Smile Assessment
For Dr. Kitchin



Please help us provide you with the dental services you want by answering this brief questionnaire.

Patient Name _____ **Date** _____

1) Are you satisfied with the appearance of your smile? □ Yes □ No

2) Would you like whiter teeth? □ Yes □ No

3) Would you like your teeth to be straighter if it could be done in a few months and without metal braces? □ Yes □ No

4) Are you missing any teeth that affect your smile or your ability to eat comfortably? □ Yes □ No

5) Do you have any broken teeth? □ Yes □ No

6) Do you wear a full or partial denture? □ Yes □ No

If yes, are you satisfied with the fit and/or appearance of it? □ Yes □ No

7) Do you have any pain in your mouth? □ Yes □ No

If yes, is it caused by temperature or chewing? □ Yes □ No

8) Do you have bad breath during the day? □ Yes □ No

9) Do your gums bleed when you brush your teeth? □ Yes □ No

10) Is there any additional information you would like to tell us?

_____

_____

Thank You for your help,

Dr. Kitchin & Staff