

Dr. Lee Centracco, DDS,PC
Cosmetic Smile Evaluation

Hold a face mirror 12"-14" from your face and *Smile*. Observe your teeth carefully and then answer the following questions:

Part 1:

- | | | |
|--|-----|----|
| 1. Do you like the appearance of your teeth and smile? | Yes | No |
| 2. Are all of your teeth in alignment (straight)? | Yes | No |
| 3. Do you have spaces or gaps that you don't like? | Yes | No |
| 4. Do you like the color of your teeth | Yes | No |
| 5. Do you like the shape of your teeth | Yes | No |
| 6. Are your teeth:
Chipped_____ Protruding_____ Hidden_____ | | |
| 7. Do you like the way your teeth come together? | Yes | No |
| 8. Are there old fillings or dental work that you don't like looking at? | Yes | No |

Part 2:

- | | | |
|---|-----|----|
| 9. Do you have "TMJ" problems? | Yes | No |
| 10. Do you grind your teeth? | Yes | No |
| 11. Do you have chronic headaches? | Yes | No |
| 12. Does your Jaw click or pop when chewing or talking? | Yes | No |
| 13. Do you have periodontal (gum) problems? | Yes | No |
| 14. Do your gums bleed when you brush your teeth? | Yes | No |
| 15. Are your gums always puffy or swollen? | Yes | No |
| 16. Do you have chronic bad breath? | Yes | No |



Complete this form, print and bring it with you for a Complimentary in-office Cosmetic Consultation and Dental Imaging. Call **405-946-5198** to schedule your appointment or email the appointment request form.