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Kid's Corner

Name _____ Date _____

Smile Analysis

Do you and your child like the appearance of their teeth and smile? *Yes* *No*
If not, please explain: _____

Are their teeth in alignment (straight)? *Yes* *No*
If not, please explain: _____

Do they have spaces/crowding that you do not like? *Yes* *No*
If yes, please explain: _____

If you could wave a magic wand, what would you like to change about your child's smile?
_____

Are their teeth: Chipped Protruding Sensitive Stained Worn

Do they hide their teeth when they smile? *Yes* *No*
If yes, please explain: _____

Do you have any other concerns about their teeth? *Yes* *No*
If yes, please explain: _____

Gums Analysis

How do you think your child's gums look? Do they look healthy? If not, please explain: _____
_____

Do their gums bleed when you brush them? *Yes* *No*

Does your child have chronic bad breath? *Yes* *No*

How often does your child brush? _____ floss? _____

Who brushes your child's teeth? Child Parent

Your answers will help US achieve YOUR goals!