RISIO®
clear aligners

PATIENT SMILE ASSESSMENT

Your Personal Details

Title (Mr, Mrs, Miss, Ms, other title)	
First names(s) (please include all forenames in full)	
Surname	
Address	
Postcode	
Date of Birth D D M M Y Y	
Home telephone number	Mobile telephone number
Email address	Occupation

Dental History

What prompted you to seek dental treatment at this time?

What words best describe your past dental experiences?

Caring ☐ Relaxed ☐ Modern ☐ Painful ☐ Stressful ☐ Rushed ☐ Sympathetic ☐

Rushed ☐ Good value ☐ Uncomfortable ☐ High-Tech ☐ Old fashioned ☐ No choice ☐

Patient Questions

Has the fear or discomfort kept you from regular visits?	Yes ☐	No ☐
Have you experienced any discomfort from your teeth recently?	Yes ☐	No ☐
Are you aware of any grinding or clenching of your teeth?	Yes ☐	No ☐
Do your jaw joints ever click or hurt?	Yes ☐	No ☐
Do you suffer from headaches or migraine pains in your face or your ear?	Yes ☐	No ☐
Do your gums bleed easily, feel tender or irritated?	Yes ☐	No ☐
Are you troubled with bad breath or a bad taste?	Yes ☐	No ☐
Do you like your smile?	Yes ☐	No ☐
Do you like the shape of your teeth?	Yes ☐	No ☐
Do you like the shade of your teeth?	Yes ☐	No ☐
Do you like the way your teeth bite together?	Yes ☐	No ☐
Do you have any missing teeth?	Yes ☐	No ☐
Are all your teeth straight?	Yes ☐	No ☐
Are any teeth chipped or hidden?	Yes ☐	No ☐
Are any old fillings becoming dark or stained?	Yes ☐	No ☐

What would you like to change most (be specific)?

Treatment Options

Would you like to know more about any of the fol lowing:

Teeth whitening	Yes	☐	No	☐	Teeth straightening	Yes	☐	No	☐
Replacing missing teeth	Yes	☐	No	☐	Softening lines/wrinkle reduction	Yes	☐	No	☐

Clinical photographs play a key role in the education of the dental team, and are often required for treatment planning. By signing you give permission for photographs of my/the patient's face, jaws or teeth before, during, or after completion of treatment. You consent to allow the photographs/videos to be used for the following purposes: Dental Research, Dental Education (e.g. lectures, seminars, patient education material), Professional Publications (e.g. journals, books, articles), Marketing Material (e.g. websites, patient information leaflets).

Patient Signature (or parent/guardian signature if under 16) _____ Date _____

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