SMILE Analysis Form

Clinical Evaluation (Edited VBH 11-1-00)

FACIAL COMPONENTS

Smile / Facial Symmetry (Describe deviations)

YES NO Face divided into equal thirds? ____________________________________________
YES NO Interpupillary Line = Horizon? ____________________________________________
YES NO Midline of eyes, nose and chin in line? ____________________________________

YES NO Interpupillary line perpendicular with facial midline? _________________________
YES NO Commissure line perpendicular with facial midline? __________________________
YES NO Incisal edges line perpendicular with facial midline? _________________________

YES NO Proper functional incisal edge length and position (say “F”, “V”) ______________
YES NO Does patient guard their smile?

Maximum Smile

At rest smile, ___ mm of centrals showing:
Full smile, ___% of centrals showing:
Full smile: ___ mm tissue above centrals showing:
Full smile: ___ Discoloration in gingivae above teeth
Full smile: ___ mm of lip movement from rest

Smile Form of lower lip:
Curved
Straight
Reverse
Asymmetric

Smile form of upper lip?
Curved
Straight
Reverse
Asymmetric

YES NO Maxillary centrals 50% of 6-11 width? ________________________________
YES NO Interproximal spaces visible? _________________________________________
YES NO Mandibular lip line follows incisal edges? ______________________________
YES NO Incisal edges touch lower wet-dry line? _________________________________
YES NO Balanced bilateral negative space? _____________________________________
YES NO Occlusal plane A-P correct? __________________________________________

DENTAL COMPONENTS (Describe deviations)

Dental Midline

YES NO Maxillary dental midline coincident with facial midline ___________________
YES NO Max / Mand midlines coincident? _______________________________________

Tooth Proportion

YES NO Tooth height to width ratio(75%) approximates Golden Proportion (1.6)?
YES NO Length of central incisors 10-11 mm?
YES NO Central-lateral-canine in proper ratio (golden proportion)?
YES NO Anterior teeth with proper line angle location and shape?
YES NO Posterior teeth length in harmony and appear progressively smaller?
**Axial Alignment**
YES  NO  Axial alignment inclines to midline?  ______________________
YES  NO  Any flared teeth present?  ________________________________
YES  NO  Buccal corridors visible?  ________________________________

**Proximal Contacts**
YES  NO  Proper inciso-gingival proximal contact position?  ______________________
YES  NO  Proper incisal embrasure form?  ________________________________
YES  NO  Spaces gingival to contacts (black hole)  ________________________________
YES  NO  Diastemas?  ________________________________________________

**Tooth Shade and Surface Characterization (see Bleaching Analysis form)**
YES  NO  Overall shade discrepancy present?  ________________________________
YES  NO  Individual tooth shade discrepancy?  ________________________________
YES  NO  Notable surface characterization?  ________________________________

**GINGIVAL COMPONENT**
YES  NO  Gingiva in harmony with upper lip?  ________________________________
YES  NO  Gingiva confluent with DEJ?  __________________________________
YES  NO  Proper Canine-Lateral-Central Position?  ________________________________
YES  NO  Proper Gingival Embrasures?  __________________________________
YES  NO  Healthy Gingival Papillae?  __________________________________
YES  NO  Inflammation/Discoloration present?  ________________________________
YES  NO  Excessive gingival tissue (Cause)?  ________________________________

**Restorations**
YES  NO  Defective Restorations Present  
Tooth # ___ / Description  __________________________________
Tooth # ___ / Description  __________________________________
Tooth # ___ / Description  __________________________________
Tooth # ___ / Description  __________________________________
Tooth # ___ / Description  __________________________________
Tooth # ___ / Description  __________________________________

**Patient Comments**
YES  NO  Is the patient pleased with overall smile?  ________________________________
YES  NO  Is there anything the patient would like to change about their smile?  

Chief Complaint  __________________________________

**Summary Diagnosis:**

**Consultation Required**
YES  NO  Prosthodontic  __________________________________
YES  NO  Periodontic  __________________________________
YES  NO  Orthodontic  __________________________________
YES  NO  Oral Surgery  __________________________________
YES  NO  Endodontic  __________________________________
Patients’ Esthetic Self-Analysis

PATIENT INSTRUCTIONS: Looking into a full face, close-up mirror, analyze your smile in two phases - slight smile and full smile.

TEETH

YES  NO  In a slight smile, with your lips slightly parted, do the tips of your front teeth show?

YES  NO  In a full smile, is there anything you do not like about your smile? Explain:

Look at the two upper front teeth:
ARE THEY: slightly longer than the others, equal in length or shorter? (circle one answer)

YES  NO  Do any teeth look too long or too short?

YES  NO  Do any teeth look too pointed or too flat?

YES  NO  Do any teeth have a shape you do not like?

YES  NO  In a full smile, does the top lip rise above the necks of the teeth so that the gums show?

YES  NO  When you bite on your back teeth (when you swallow), do all the front teeth come into contact?

YES  NO  When you bite on your front teeth (biting a sandwich), do all the front teeth come into contact?

YES  NO  Are the upper front teeth straight (versus being crooked, overlapped, or protruding)?

YES  NO  Are the lower six front teeth straight?

YES  NO  Are the lower front teeth even in appearance?

YES  NO  Are the teeth of one color from top to bottom?

YES  NO  Do you like the color of your teeth?

YES  NO  Is one front tooth darker than the rest?
YES  NO  Do the teeth contain any stains? (white or brown)

YES  NO  Do the front teeth contain fillings that are not matched with other teeth so they are noticed?

YES  NO  In a full smile, sometimes the back teeth show. Are these teeth free of stains and discolorations?

YES  NO  Do the necks of any teeth have erosion (a ditched-in "V" appearance that can be seen or felt with the fingernail)?

GUMS

YES  NO  Are the gums pink and healthy-looking everywhere? (versus red and swollen).

YES  NO  Have the gums receded from the necks of the teeth anywhere?

YES  NO  Is the curvature of the gum tissue good around the teeth (half-moon shape)?

BREATH

YES  NO  Is your breath always pleasant?

YES  NO  Do you use mouthwash or some other treatment for bad breath?

YES  NO  Do you brush your tongue?

YES  NO  Do you have a problem with throat drainage or sinuses?

YES  NO  Is your mouth free from decay or gum disease that cause bad breath?

How frequently do you brush (and with what toothpaste and firmness of toothbrush)?

How frequently do you floss (and with what kind)?

SNORING

YES  NO  Does anyone tell you that you snore?

YES  NO  Does your snoring annoy anyone?

YES  NO  Does anyone tell you that you stop breathing while sleeping?