manus
A Dental World of Difference®

☺ SMILE ANALYSIS ☺

When I see a picture of myself, the first thing I notice about my smile is: _____

Something I often notice about other smiles I consider attractive is _____

Aside from yourself, who is the next most important person you would want to "like" your new smile: _____

***Please mark an "X" by the statements below that you agree with.**

___ I wish the color of my teeth were whiter.

___ I wish I had a broader smile.

___I think some of my teeth are too large.

___I wish my teeth were straighter.

___I think my gums show too much when I smile.

___ I think my smile shows too much space between some of my teeth.

___Because I am not totally pleased with my smile, I sometimes hesitate to smile.

___ I have often wished I could change some the features of my smile.

___I feel as though I don't really know all the options available for enhancing my smile.

___Concerns over fees have prevented me from taking advantage of some the available option to enhance my smile.

___I feel as though I could do a better job protecting the health of my teeth and gums, and therefore the longevity of my own smile. ☺

To be completed by participant: Please Print

First Name _____ Last Name_____ Age:_____ D.O.B._____

Address:_____ City:_____ State:_____ Zip:_____

Phone:_____ Occupation:_____

Questionnaire:

I have been treated for skin cancer of the Head and Neck: ____Yes ____No; other cancer___Yes ____No

Location_____

I have family members who have been treated for cancer of the Head and Neck region ____Yes ____No;

Location_____

I currently use tobacco (please circle) Chewing Snuff Cigarettes Cigar Pipe None

I previously used tobacco (please circle) Chewing Snuff Cigarettes Cigar Pipe None

In my lifetime I have used tobacco for ____year(s), with an average of ____packs per day ____None

I have consumed alcohol beverages for total of ____year(s), with an average of _____drinks per day ____None

Please circle the Head and Neck Problem that you have:

Change in voive Y N Bleeding Y N Earache Y N Swelling in Head/Neck Y N

Sore Throat Y N Lump in Throat Y N Difficulty Swallowing Y N Denture Problem Y N

Soreness in Mouth Y N Tooth/Gum Problem Y N Grown in Neck Y N

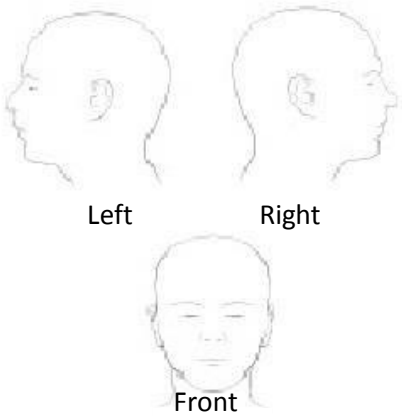
Release of Liablity:

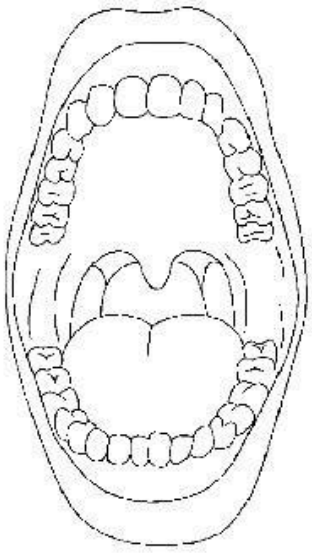
I hereby release Manus Health System, screening physicians and all other health care personnel of all responsibility associated with this screening evaluation and results. I accept all responsibility for the evaluation, future costs of further medical evaluation, diagnositc tests and treatment in addition to the pursuit of any recommendation providing understanding that this examination is not intended to be a complete head and neck examination or substitute for any examination by future of past practitioners. I am responsible for any follow up examination, evaluation, or test and release all other parties' responsibility. the results of this examination and the information on the form may be used by Manus Health System for statistical and clinical purposes, but my name will not be released to any other person or organization without my written consent.

Signature _____ Date: _____

Screening Examination: (to be completed by physician) Please check all the apply

Site	Normal	Abnormal	Not Evaluated
Skin	_____	_____	_____
Ears	_____	_____	_____
Nose	_____	_____	_____
Oral	_____	_____	_____
Oropharynx	_____	_____	
Salivay Glands	_____	_____	_____
Thyroid Glands	_____	_____	_____
Neck	_____	_____	_____





1. Routine Follow up with primary care physician
2. Further head and neck evalution may be necessary
3. Immediate consultation for suspected neoplasem
4. Other
5. None

Signature _____ Date: _____