SMILE ON 65+ Screening Form

***Screening should be completed annually**

Patient: _____ Clinic: _____

Today's Date: _____ Clinic Worker: _____

1. **Do you have removable dentures?** ☐No ☐Upper ☐Lower
2. **Do you usually wear your denture(s) when you eat?** ☐No ☐Upper ☐Lower
3. **Is patient currently edentulous?** ☐Yes ☐No
4. **Untreated Decay:** ☐Yes ☐ No ☐Edentulous
5. **Root Fragments:** ☐Yes ☐No ☐Edentulous
6. **Need for Periodontal Care:** ☐Yes ☐No ☐Edentulous
7. **Suspicious Soft Tissue Lesions:** ☐Yes ☐No
8. **Treatment Urgency:**
   - ☐No obvious problem
   - ☐Early care-within next several weeks
   - ☐*Urgent Care - within next week due to pain or infection*
9. **How often do you brush your teeth?**
   ☐None ☐ Once Daily ☐Twice Daily ☐Three Times Daily ☐Four Times Daily
10. **Have you experienced any of the following problems related to your mouth and teeth during the past 12 months?** (Check all that apply)
    - ☐Difficulty when biting or chewing foods ☐Difficulty with speech or pronouncing words
    - ☐Dry mouth ☐Felt Anxiety ☐Felt embarrassment
    - ☐Avoided smiling ☐Experienced pain or discomfort
11. **Are there Before and After Photos?** ☐Yes ☐No

    If so, where are they saved? _____