Smile Evaluation

Name:_____Date:_____

To aid in our diagnosis and treatment of your esthetic concerns, please take a moment and answer the following questions. Please circle your answer.

Do you dislike the color of your teeth?	YES NO
Do you have spaces between your teeth that bother you?	YES NO
Do you have chips or uneven edges on your teeth?	YES NO
Do you feel that your teeth are too long or too short?	YES NO
Do you have dark fillings that show when you smile?	YES NO
Do your gums show too much when you smile?	YES NO
Are your teeth crowded or crooked?	YES NO
Do you have existing crowns or dental work that you consider "ugly"?	YES NO
Are you self-conscious of your teeth and/or smile?	YES NO
Has anyone (family member, friend, etc.) ever suggested that you should have something done with your teeth or smile?	YES NO
Do you avoid smiling when you have your picture taken?	YES NO
Would you like to improve your existing smile?	YES NO
Do you wish you had a "new smile"?	YES NO

What concerns do you have regarding dental treatment to improve your smile?

- ❑ Fear of treatment
- ❑ Time of treatment concerns
- ❑ Financial concerns
- ❑ Distance to office
- ❑ Not understanding treatment
- ❑ Embarrassment
- ❑ Other