Patient Smile Evaluation Form

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 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

Place a checkmark next to which of the following are concerns 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:_____