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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.

- | | | |
|---|-----|----|
| 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 silver/mercury fillings that show 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 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 treatment to improve your smile:

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

Additional Comments: _____

