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: _____

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