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 choose 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
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 about 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

Please mark which of the following are concerns you have regarding your dental treatment to improve your smile:

- ○ Fear of Treatment
- ○ Time of treatment concerns
- ○ Financial Concerns
- ○ Distance to office
- ○ Not understanding treatment
- ○ Embarrassment

Other: _____