Smile Assessment Form

Please consider each statement carefully and circle YES OR NO. The doctor and members of the dental team will discuss your responses with you in confidence.

1. I am concerned about the appearance of my teeth or my smile.

*YES or NO

2. I am concerned about the whiteness/lack of whiteness of one or more of my teeth.

*YES or NO

3. I am concerned about the position or angle of one or more than one of my teeth.

*YES or NO

4. I am concerned about the shape of one or more than one of my teeth.

*YES or NO

5. In social situations, I am sometimes embarrassed by my teeth or my smile.

*YES or NO

6. There are some things about my upper front teeth that I would like to change.

*YES or NO

7. There are some things about my lower front teeth that I would like to change.

*YES or NO

8. I have old fillings or previous dental treatment that is no longer satisfactory to me.

*YES or NO

9. I am missing one or more of my teeth.

*YES or NO

10. I am interested in learning more about esthetic dentistry.

*YES or NO

Please use the space below to indicate any other problems, concerns, or questions. We will make every effort to listen attentively to your concerns so that we can present you with the best possible treatment options. Thank You.