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MASTERSHIP ACADEMY GENERAL DENTISTRY

Family & Cosmetic Dentistry

Located in The Super Target Center
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(954) 741-4500

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.

1.	Do you dislike the color of your teeth?	☐ Yes ☐ No
2.	Do you have spaces between your teeth that bother you?	☐ Yes ☐ No
3.	Do you have chips or uneven edges on you teeth?	☐ Yes ☐ No
4.	Do you feel that your teeth are too long or too short?	☐ Yes ☐ No
5.	Do you have dark fillings that show when you smile?	☐ Yes ☐ No
6.	Do your gums show too much when you smile?	☐ Yes ☐ No
7.	Are your teeth crowded or crooked?	☐ Yes ☐ No
8.	Do you have existing crowns or dental work you consider "ugly"?	☐ Yes ☐ No
9.	Are you self-conscious of your teeth and/or smile?	☐ Yes ☐ No
10.	Has anyone (family member, friend, etc.) ever suggested that you should have something done with your teeth or smile?	☐ Yes ☐ No
11.	Do you avoid smiling when you have your picture taken?	☐ Yes ☐ No
12.	Would you like to improve your existing smile?	☐ Yes ☐ No
13.	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
- ☐ Scheduling Problems
- ☐ Financial Concerns
- ☐ Distance to Office
- ☐ Not Understanding treatment
- ☐ Embarrassment
- ☐ Other: Explain _____