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 your 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 __________________________________________