SMILE EVALUATION

Patients 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.

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___
Do your gums show too much when you smile?	YES___ NO___
Are your teeth crowded or crooked?	YES___ NO___
Do you have existing crowns or dental work that you consider "ugly"?	YES___ NO___
Are you self conscious of 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___
Do you wish you had a "new smile"?	YES___ NO___

What concerns do you have regarding dental treatment to improve your smile?

☐ Fear of treatment
☐ Time of treatment concerns
☐ Financial concerns
☐ Distance to office
☐ Not understanding treatment
☐ Embarrassment
☐ Other:
_____

When restorative treatment is completed in our office, we offer a three-year warranty. We will replace or redo your restorative treatment ***providing*** *you come in for your hygiene recall appointment and complete all recommended treatment.*