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Smile Evaluation Checklist

Name: _____ Date: _____

Hold a mirror 12-14" from your face and smile to show your teeth. 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 our smile?

- | | | |
|--|---|--------------------------------|
| <input type="checkbox"/> Fear of treatment | <input type="checkbox"/> Financial concerns | <input type="checkbox"/> Other |
| <input type="checkbox"/> Time of treatment concerns | <input type="checkbox"/> Distance to office | |
| <input type="checkbox"/> Not understanding treatment | <input type="checkbox"/> Embarrassment | |