

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.

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| 1. | I am concerned about the general appearance of my teeth or my smile. | YES | NO |
| 2. | I am concerned about the level of whiteness of one or more of my teeth. | YES | NO |
| 3. | I am concerned about the position or alignment of one or more of my teeth. | YES | NO |
| 4. | I am concerned about the shape of one or more of my teeth. | YES | NO |
| 5. | In social situations, I am somewhat embarrassed by my teeth or my smile. | YES | NO |
| 6. | There are some things about my upper front teeth that I would like to change. | YES | NO |
| 7. | There are some things about my lower front teeth that I would like to change. | YES | NO |
| 8. | I have old fillings or previous dental work that is no longer or has never been satisfactory to me. | YES | NO |
| 9. | I am missing one or more of my front/back teeth. | YES | NO |
| 10. | I am interested in learning more about cosmetic dentistry. | YES | NO |

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

Thank you!