NAME_____

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.

1.	I am concerned about the appearance of my teeth or my smile.	YES NO
2.	I am concerned about the whiteness/lack of whiteness of one or more of my teeth.	YES NO
3.	I am concerned about the position or angle 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 sometimes 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 teeth that I would like to change.	YES NO
8.	I have old fillings or previous dental treatment that is no longer satisfactory to me.	YES NO
9.	I am missing one or more of my teeth.	YES NO
10.	I am interested in learning more about esthetic dentistry.	YES NO

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

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