

# Patient Smile Evaluation Checklist

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 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