SMILE ASSESSMENT FORM

Please consider each statement carefully and circle Yes or No. The doctor and members of your dental team will discuss your responses with you in confidence. Thank You!

1. I am concerned about the appearance of my teeth and/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 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 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