Patient Smile Assessment

It is our goal to offer solutions that are in alignment with what is most important to you. Your smile is an important aspect of your appearance and how you present yourself. The questions below will help you honestly analyze your smile

Please answer Yes or No to the following:

1. Do you like the way your teeth look?	YES	NO
2. Do you ever have difficulty eating, chewing or drinking?	YES	NO
3. Do any prior dental restorations or other dental work appear unnatural or too noticeable (such as silver fillings or crowns)?	YES	NO
4. Do you have teeth that are crooked, misaligned, crowded, or uneven?	YES	NO
5. Do any of your teeth appear to be too big or small (long or short)?	YES	NO
6. Do you have spaces between your teeth that you would like closed?	YES	NO
7. Would you like your teeth to be straighter?	YES	NO
8. Are your teeth chipped, or worn down from grinding?	YES	NO
9. Are your gums puffy red or tender?	YES	NO
10. Do your gums bleed when brush or floss?	YES	NO
11. Do your gums show too much when you smile?	YES	NO
12. Do you ever feel self-conscious about your teeth when you smile or laugh or do you avoid showing your teeth when smiling?	YES	NO
13. Do any of your teeth appear to be yellow, discolored, or stained?	YES	NO
14. Do you wish your teeth were brighter or whiter?	YES	NO
15. Are you interested in avoiding conventional removable dentures and/or partials, and keeping your natural teeth for life?	YES	NO
16. Is there anything you wish was different about your teeth, mouth, or smile?	YES	NO
17. Are you interested in Botox, Jevederm, Braces or Whitening?	YES	NO

Do any of the following concern you when it comes to your dental care?

Fear of dental treatment	YES	NO
Amount of time required away from work	YES	NO
Financial concerns	YES	NO
Not understanding benefits or risks of treatment	YES	NO
Embarrassment	YES	NO

Other: _____

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Signature: _____ Date: _____