



Patient Smile Evaluation Checklist

Name: _____ Date: _____

To aid our diagnosis and treatment of your esthetic concerns, please take a moment and answer the following questions. Please circle your answer.

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| Do you like 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, 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 to do treatment
- Financial
- Distance to office
- Not understanding treatment
- Embarrassment
- Other...explain