

# Smile Assessment

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.

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|---|-----|----|
| 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 front teeth that I would like to change.            | YES | NO |
| 8. I have old fillings or previous dental treatment that is not 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 cosmetic dentistry.                              | YES | NO |
| 11. Where on the line would you mark the quality of dentistry you would like in your mouth? |     |    |



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!

