Smile Assessment

Please consider each statement and carefully circle **YES** or **NO**.

The doctor and members of our dental team will discuss your responses with you in confidence.

Name:_____Date:_____

1.	I am concerned about the appearance of my teeth or smile	YES	NO
2.	I am concerned about the whiteness/lack of whiteness of my teeth	YES	NO
3.	In social situations, my teeth/smile sometimes embarrass me	YES	NO
4.	There are some things about my upper front teeth I would like to change	YES	NO
5.	There are some things about my lower front teeth I would like to change	YES	NO
6.	I have old fillings or previous dental treatment that is not satisfactory to me	YES	NO
7.	I am missing one or more of my teeth	YES	NO
8.	I am interested in improving the overall appearance of my teeth/smile	YES	NO
9.	I am concerned about the position/angle of one or more of my teeth	YES	NO
10.	I am concerned about the shape of one or more of my teeth	YES	NO
11.	I am interested in learning more about:		
	Cosmetic Dentistry	YES	NO
	Sedation Dentistry	YES	NO
	Invisalign	YES	NO
	Teeth Whitening	YES	NO

Please use the space below to indicate any other problems, concerns, or questions you may have for our dental team. We will make every effort to listen to your concerns so we may present you with the best possible treatment options.

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