

Esthetic Evaluation

To aid in our diagnosis and treatment of your esthetic concerns, please take a moment to answer the following questions. Please circle your answer below. We have tried our best to address the most common concerns presented to us by our patients, if we have failed to mention an area of particular concern to you please let us know by writing it in the area provided below. Thank you!

- | | | | |
|-----|---|----------|-----------|
| 1. | Do you like the color of your teeth? | Yes | No |
| 2. | Do you have spaces between your teeth that bother you? | Yes | No |
| 3. | Are your teeth chipped or do they have uneven edges? | Yes | No |
| 4. | Do you have a problem with the length of your teeth? | Too Long | Too Short |
| 5. | Do your gums show in a way that bothers you when you smile? | Yes | No |
| 6. | Do you have dark fillings that show when you smile? | Yes | No |
| 7. | Are your teeth too crowded or crooked? | Yes | No |
| 8. | Do you have existing crowns or dental work that you consider to be "ugly"? | Yes | No |
| 9. | Are you self-conscious about your teeth or smile? | Yes | No |
| 10. | Has anyone (friend, family member, etc.) ever suggested that you do something about your teeth or smile? | Yes | No |
| 11. | Do you avoid smiling when you have your picture taken? | Yes | No |
| 12. | Would you like to improve your existing smile? | Yes | No |
| 13. | Do you wish that you had a "new smile"? | Yes | No |
| 14. | _____ | | |

What if anything has prevented you from seeking treatment? (Circle all that apply)

- I. Fear of Treatment II. Treatment time III. Financial Concerns
 IV. Lack of Treatment Options/Understanding Options V. Embarrassment VI. Other

Name: _____

Date: _____