ESTHETIC EVALUATION

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To aid in our diagnosis and treatment of any esthetic concerns you may have, please take a moment and answer the following questions. Please circle your answer. If you are completely satisfied with the appearance of your teeth and smile, there is no need to fill out this form.

Name: ______________________________ **Date:**______________

1.	Do you dislike the color of your teeth?	YES	NO
2.	Do you have spaces between your teeth that bother you?	YES	NO
3.	Do you have chips or uneven edges on your teeth?	YES	NO
4.	Do you feel your teeth are too long or too short?	YES	NO
5.	Do you have dark fillings that show when you smile?	YES	NO
6.	Do your gums show too much when you smile?	YES	NO
7.	Are your teeth too crowded or crooked?	YES	NO
8.	Do you have existing crowns or dental work you consider "ugly"	YES	NO
9.	Are you self conscious of your teeth and/or smile?	YES	NO
10.	Would you like to improve your existing smile?	YES	NO
11.	Do you wish you had a "new smile"	YES	NO

What concerns do you have regarding dental treatment to improve your smile?

1. Fear of treatment.
2. Time of treatment concerns.
3. Financial concerns.
4. Distance to office.
5. Not understanding treatment options.
6. Embarrassment.
7. Other.

THANKS!

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