Esthetic Evaluation

To aid in our diagnosis and treatment of your esthetic concern, please take a moment and answer the following question. Please circle your answers.

Name: _____ Date:_____

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. 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 crowded or crooked?	Yes	No
8. Do you have existing crowns or dental work you consider “ugly?”	Yes	No
9. Are you self-conscience about your teeth or smile?	Yes	No
10. Do you avoid smiling for pictures?	Yes	No
11. Would you like to improve your existing smile?	Yes	No
12. Do you wish you had a “new smile?”	Yes	No

Thank you!