Smiles by design
DENTAL CARE

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Smile Assessment Form

Please consider each statement carefully and circle Y or N. During your exam today the doctor and members of the team will discuss your responses with you in confidence.

1.	I am concerned about the appearance of my teeth or smile	Y	N
2.	I am concerned about the whiteness/lack of whiteness of one or more of my teeth	Y	N
3.	I am concerned about the position or angle of one or more Of my teeth	Y	N
4.	I am concerned about the shape of more or more of my My teeth	Y	N
5.	In social situations, I am sometimes embarrassed by my Teeth or smile	Y	N
6.	There are some things about my upper front teeth that I would like to change	Y	N
7.	There are some things about my lower front teeth that I would like to change	Y	N
8.	I have old fillings or previous dental treatment that is No longer satisfactory	Y	N
9.	My bites is sometimes uncomfortable when I bite or chew	Y	N
10.	I am interested in learning more bout cosmetic dentistry	Y	N
11.	I am interested in learning more about anxiety/sedation	Y	N
12.	I am interested in learning more about tooth replacement	Y	N

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