Smile Evaluation Checklist

Name: _____ Date: _____

To aid in our diagnosis and treatment of your esthetic concerns, please take a moment to answer the following questions. Please circle your answer.

Do you dislike the color of your teeth?	Yes	No
Do you have spaces between your teeth that bother you?	Yes	No
Are your teeth crowded or crooked?	Yes	No
Do you have chips or uneven edges on your teeth that bother you?	Yes	No
Do you feel that your teeth are too long or too short?	Yes	No
Do you have dark fillings that show when you smile that bothers you?	Yes	No
Do your gums show too much when you smile?	Yes	No
Do you have existing crowns or dental work that you are not happy with?	Yes	No
Are you self-conscious of your teeth and/or smile?	Yes	No
Has anyone (family member, friends, etc) ever suggested that you should have something done with your teeth or smile?	Yes	No
Do you avoid smiling when you have your picture taken?	Yes	No
Would you like to improve your existing smile?	Yes	No
Do you wish you had a “new smile”?	Yes	No