Smile Assessment Form

Please consider each statement carefully and circle YES or NO. The doctor and members of the dental team will discuss your responses with you in confidence.

1. I am concerned about the general appearance of my teeth or my smile. YES NO

2. I am concerned about the level of whiteness of one or more of my teeth. YES NO

3. I am concerned about the position or alignment of one or more of my teeth. YES NO

4. I am concerned about the shape of one or more of my teeth. YES NO

5. In social situations, I am somewhat embarrassed by my teeth or my smile. YES NO

6. There are some things about my upper front teeth that I would like to change. YES NO

7. There are some things about my lower front teeth that I would like to change. YES NO

8. I have old fillings or previous dental work that is no longer or has never been satisfactory to me. YES NO

9. I am missing one or more of my front/back teeth. YES NO

10. I am interested in learning more about cosmetic dentistry. YES NO

11. I am concerned about my snoring. YES NO

12. I often feel tired or fatigued after sleep. YES NO

13. I am concerned someone noticed that I quit breathing during sleep. YES NO

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