Smile Assessment Form

Please consider each statement carefully and circle YES or NO. The doctor and team members will be happy to discuss your responses with you in confidence.

1.	I have concerns about the appearance of my teeth or my smile.	YES	NO
2.	I have concerns about the whiteness/lack of whiteness of one or more of my teeth.	YES	NO
3.	I have concerns about the position or angle of one or more of my teeth.	YES	NO
4.	I have concerns about the shape of one or more of my teeth.	YES	NO
5.	I am sometimes embarrassed by my teeth or my smile in social situations.	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 treatment that is no longer satisfactory to me.	YES	NO
9.	I am missing one or more of my teeth.	YES	NO
10.	I often cannot eat or chew the food that I used to enjoy.	YES	NO