Advanced Dental Arts

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