Smile Evaluation Questionnaire

Harry Randel DMD

Name:_____________________________________ Date:______________

To get to know you better and aid in our diagnosis and treatment of your esthetic concerns, please take a moment and answer the following questions.
Please circle your answer. Thank you! ☺

Do you dislike the color of your teeth? YES NO

Do you have spaces between your teeth that bother you? YES NO

Do you have chips or uneven edges on your teeth? 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? YES NO

Do your gums show too much when you smile? YES NO

Are your teeth crowded or crooked? YES NO

Do you have existing crowns or dental work that you consider "ugly"? YES NO

Are you self-conscious of your teeth and/or smile? YES NO

Has anyone (family member, friend, 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

Does your bite feel comfortable? YES NO

Do you ever grind your teeth? YES NO

Have you thought you needed braces? YES NO

If there were an immediate/affordable way to whiten your smile,would you be interested? YES NO

What concerns do you have regarding dental treatment to improve your smile?

- ❑ Fear of treatment
- ❑ Time of treatment concerns
- ❑ Financial concerns
- ❑ Distance to office
- ❑ Not understanding treatment
- ❑ Embarrassment
- ❑ Other ____________________________________