Tell Us What You Think About Your Smile

Name _____

	Satisfied	**Neutral**	**Unsatisfied**
1. Are you satisfied with your teeth?	____	____	____
2. How would you rate the appearance of your teeth?	____	____	____
3. Rate the color of your teeth.	____	____	____
4. Rate the shape of your teeth.	____	____	____
5. Rate the alignment of your teeth.	____	____	____
6. Rate the appearance of previous restorations.	____	____	____
7. Rate the appearance of your gum tissues.	____	____	____
	Yes	**No**	**Maybe**
8. Do you have sensitive teeth?	____	____	____
9. Would you like to improve your existing smile?	____	____	____
10. Are you concerned you have bad breath?	____	____	____
11. Do you have any missing teeth?	____	____	____
Would you like to replace them?	____	____	____

12. If you could change one thing about your smile, what would it be?

_____

_____

13. On a scale of 1 to 10 how would you rate your smile? ____

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

Fear____ Time____ Financial____ Distance to office____ Embarrassment____

Not understanding what can be done____ No Concerns____

Other_____

Please complete this form and bring to your next appointment. We will keep this in complete confidence, unless requested otherwise.