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DENTAL HEALTH GROUP  
"PASSIONATE FOR BEAUTIFUL SMILES"

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## Smile Evaluation Checklist

Name \_\_\_\_\_ Date: \_\_\_\_\_

To aid in our diagnosis and treatment of your esthetic concerns, please take a moment to answer the following questions. Please circle your answer.

- |   |     |    |
|---|-----|----|
| 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 are not happy with?   | 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 |