# Aesthetic Evaluation

**To aid in our diagnosis and treatment of your aesthetic concerns, please take a moment and answer the following questions. If you are completely satisfied with the appearance of your teeth there is no need to fill out this form.**

**Name: _____ Date: _____**

**Email Address: _____**

**Home Address: _____**

**Cell Number: _____**

**Phone Number: _____**

| | | | |
|---|---|---|---|
| 1. | Do you dislike the color of your teeth? | ( ) YES | ( ) NO |
| 2. | Do you have spaces between your teeth that bother you? | ( ) YES | ( ) NO |
| 3. | Do you have chips or uneven edges on your teeth? | ( ) YES | ( ) NO |
| 4. | Do you feel your teeth are too long or too short? | ( ) YES | ( ) NO |
| 5. | Do you have dark fillings that show when you smile? | ( ) YES | ( ) NO |
| 6. | Do your gums show too much when you smile? | ( ) YES | ( ) NO |
| 7. | Are your teeth too crowded or crooked? | ( ) YES | ( ) NO |
| 8. | Do you have existing dental work you consider 'ugly'? | ( ) YES | ( ) NO |
| 9. | Are you self-conscious of your teeth and/or smile? | ( ) YES | ( ) NO |
| 10. | Has any one (friend, family member, etc.) ever suggested that you do something about your teeth or smile? | ( ) YES | ( ) NO |
| 11. | Do you avoid smiling when you have your picture taken? | ( ) YES | ( ) NO |
| 12. | Would you like to improve your existing smile? | ( ) YES | ( ) NO |
| 13. | Do you wish you had a 'new smile'? | ( ) YES | ( ) NO |
| 14. | Are you interested in seeing how we can improve your smile with either digital imaging or a trial smile? | ( ) YES | ( ) NO |

**What concerns do you have regarding dental treatment to improve your smile?**
(check all that apply)

1. Fear of treatment ( )
2. Time of treatment ( )
3. Not understanding treatment ( )
4. Embarrassment ( )
5. Other ( )