

Smile Evaluation

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—| DDS |—

DENTISTRY PERFECTED

Member of

“The American Academy of Cosmetic Dentistry”

Name _____ Date _____

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 in 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 crowns or dental work you consider “ugly”? YES NO
9. Are you self-conscious of your teeth and/ or smile? YES NO
10. Has anyone (friend, family member, ect.) ever suggested that you should do something about your 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

What concerns do you have regarding dental treatment to improve your smile?
(Please circle)

Fear of treatment

Time of treatment concerns

Financial concerns

Distance to office

Not understanding treatment

Embarrassment

Other