

Smile Assessment Form

Please consider each statement carefully and circle **YES** or **NO**. Dr. Hamilton and members of the dental team will discuss your responses with you in confidence.

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| 1. I am concerned about the appearance of my teeth or smile. | YES | NO |
| 2. In social situations, I am embarrassed by my teeth or my smile. | YES | NO |
| 3. There are some things about my upper front teeth that I would like to change. | YES | NO |
| 4. There are some things about my lower front teeth that I would like to change. | YES | NO |
| 5. My smile is very important in my job as I deal with the general public. | YES | NO |
| 6. I am concerned with the whiteness/lack of whiteness of 1 or more of my teeth. | YES | NO |
| 7. I am concerned about the position or angle of one or more of my teeth. | YES | NO |
| 8. I am concerned about the shape of one or more of my teeth. | YES | NO |
| 9. I am interested in learning more about cosmetic dentistry. | YES | NO |
| 10. I am missing one or more of my teeth. | YES | NO |
| 11. I would like to know more about implant dentistry. | YES | NO |
| 12. Does your spouse like your smile? | YES | NO |

If I could change one thing about my smile I would _____

_____.

Please use the space below to indicate any other problems, concerns, or questions. We will make every effort to listen attentively to your concerns so that we can present you with the best possible treatment options. Thank you.