

Patient Smile Assessment

Evaluate your smile



	<u>Yes</u>	<u>No</u>
Do you like to smile wide enough to show your teeth?	<input type="checkbox"/>	<input type="checkbox"/>
Are you happy with the way your teeth look?	<input type="checkbox"/>	<input type="checkbox"/>
Do you like the look of your crowns and fillings?	<input type="checkbox"/>	<input type="checkbox"/>
Are you satisfied with the whiteness of your teeth?	<input type="checkbox"/>	<input type="checkbox"/>
Are your teeth too long? Too short?	<input type="checkbox"/>	<input type="checkbox"/>
Do you brush your teeth very hard?	<input type="checkbox"/>	<input type="checkbox"/>
Are you missing teeth?	<input type="checkbox"/>	<input type="checkbox"/>
Are you interested in improving the appearance of your teeth?	<input type="checkbox"/>	<input type="checkbox"/>
Are you familiar with the benefits of implants?	<input type="checkbox"/>	<input type="checkbox"/>
Do your teeth or gums hurt?	<input type="checkbox"/>	<input type="checkbox"/>
Are you anxious or fearful of treatment?	<input type="checkbox"/>	<input type="checkbox"/>
Are you interested in esthetic (cosmetic) dentistry?	<input type="checkbox"/>	<input type="checkbox"/>
Would you like to learn more about modern cosmetic procedures?	<input type="checkbox"/>	<input type="checkbox"/>

If you could change something about your smile, what would it be?
