



Smile Profile

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

Name _____ Date _____

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|---|-----|----|
| 1. Are you pleased with the appearance of your smile? | Yes | No |
| 2. Would you like your teeth to be whiter? | Yes | No |
| 3. Do you have chips or uneven edges on your teeth? | Yes | No |
| 4. Do you have dark fillings that show when you smile? | Yes | No |
| 5. Do you have spaces between your teeth that bother you? | Yes | No |
| 6. Are your teeth crowded or crooked? | Yes | No |
| 7. Do you have existing crowns or dental work that you consider "ugly"? | Yes | No |
| 8. Do you avoid smiling when having your picture taken? | Yes | No |
| 9. Do you wish you had a new smile? | Yes | No |

What reasons might be preventing you from improving your smile?

- | | |
|----------------------|---------------------|
| A. Fear of treatment | B. Time Constraints |
| C. Finances | D. Other _____ |