VER: 02/2014

BayView DENTAL Associates

expect something to smile about

Patient Name: _____ Date: _____

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

- Do you dislike the color of your teeth? **YES NO**
- Do you have spaces between your teeth that bother you? **YES NO**
- Do you have chips or uneven edges on your teeth? **YES NO**
- Do you feel that your teeth are too long or too short? **YES NO**
- Do you have dark fillings that show when you smile? **YES NO**
- Do your gums show too much when you smile? **YES NO**
- Are your teeth crowded or crooked? **YES NO**
- Do you have existing crowns or dental work you consider "ugly"? **YES NO**
- Are you self-conscious of your teeth and/or smile? **YES NO**
- Has anyone (family member, friend, etc.) ever suggested that you should have something done with your teeth or smile? **YES NO**
- Do you avoid smiling when you have your picture taken? **YES NO**
- Would you like to improve your existing smile? **YES NO**
- Do you wish you had a "new smile"? **YES NO**

Place a checkmark next to which of the following are concerns you have regarding dental treatment to improve your smile:

☐ Fear of treatment
☐ Time of treatment concerns
☐ Financial Concerns
☐ Distance to office
☐ Not understanding treatment
☐ Embarrassment
☐ Other: _____