Patient Smile Evaluation Form

Name:_____ Date: _____

To aid in our diagnosis and treatment of your esthetic concerns, please take a moment and answer the following questions. Please check 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-conscience of your teeth and/or smile?	❑ Yes ❑ No

Has anyone ever suggested that you should have something done with your teeth/smile?
❑ Yes ❑ No

Do you have concerns regarding dental treatment to improve your smile?

Fear of treatment	❑ Yes ❑ No
Time of treatment concerns	❑ Yes ❑ No
Financial concerns	❑ Yes ❑ No
Distance to office	❑ Yes ❑ No
Understanding treatment	❑ Yes ❑ No
Embarrassment	❑ Yes ❑ No

We’d like your feedback!

_____

_____

_____

Dr Marc Panet-Raymond DDS 150 Madrona Ave SE Salem OR 97302 503-362-3719