DISTRICT DENTAL

Name: _____

Date: _____

**How would you rate your smile?**
- ☐ It's awesome! I love it!
- ☐ I'm quite happy with my smile but would consider some minor changes
- ☐ It's OK (mild dissatisfaction)
- ☐ I'm unhappy with the appearance of my teeth
- ☐ I'm embarrassed to smile or show my teeth

**If you could make any changes to your smile, what changes would you make?**

_____
_____
_____

**Would you prefer having brighter teeth?**
- ☐ Yes
- ☐ No
- ☐ Indifferent

**In terms of teeth length, do you feel your teeth are:**
- ☐ Too long
- ☐ Too short
- ☐ Just right

**Are you happy with how much your teeth show when you smile?**
- ☐ Shows too much
- ☐ Does not show enough
- ☐ Just right

**Would you like to change the angle or orientation of any teeth? (slanted or rotated)**
- ☐ Yes
- ☐ No

**Do you have any staining or mottling you'd like to have removed?**
- ☐ Yes
- ☐ No

**How do you feel about the amount of gum tissue that shows when you smile?**
- ☐ Too much
- ☐ Not enough
- ☐ Just right

**Do you think the gum tissue around your teeth is symmetrical?**
- ☐ Gum tissue seems higher over some teeth
- ☐ Gums seem symmetrical

**Do you have any dark crown margins that are visible?**
- ☐ Yes
- ☐ No

**Do you have purple or inflamed gums around a crown or filling?**
- ☐ Yes
- ☐ No

**Are you concerned about wear or chipping on your front teeth?**
- ☐ Very concerned
- ☐ Moderately concerned
- ☐ Not really concerned

**Do you have any dark spaces, or triangles, between your front teeth?**
- ☐ Yes
- ☐ No

**Are you self-conscious about visible dark metal fillings when you smile?**
- ☐ Yes
- ☐ No

**Please identify all concerns you have regarding your dental treatment to improve you smile and rate them from most to least.**

____ Fear of Treatment
____ Time or Length of Treatment
____ Financial Concerns
____ Travel time
____ Not Understanding Treatment
____ Embarrassment
____ Other _____
____ Other _____

**Additional Comments:**

_____
_____
_____