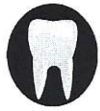

Michael A. Sweeney D.M.D.

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Patient Smile Evaluation

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 like the color of your teeth?	Y	N
Do you have spaces between your teeth that bother you?	Y	N
Are your teeth crowded or crooked?	Y	N
Do you have existing dental work you consider "ugly"?	Y	N
Are you self-conscious of your teeth and/or smile?	Y	N
Would you like to improve your existing smile?	Y	N
Do you snore?	Y	N
Are your teeth wearing down or chipping on the biting surface?	Y	N
Do you have with jaw pain?	Y	N

Please place a checkmark next to any of the follow concerns you may have:

□ Fear of treatment

□ Scheduling problems

□ Financial concerns

□ Not understanding treatment

□ Other - Explain ____

____

____