



Bonner & Huriega

Tomorrow's Technology with Personalized Care

Patient Smile Evaluation Form

Name: _____ Date: _____

A simple questionnaire to help us create the SMILE you have always wanted!

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