Dr. Amy Reese, D.D.S.

Smile Evaluation

Date: _____ Patient Name:_____

To aid in our diagnosis and treatment of your esthetic concerns, please take a moment to answer the following questions. It's our desire to ensure that you are happy with your smile. Thank you!

Do you dislike the color of your teeth?	Yes	No
Do you have any spaces in your teeth that bother you?	Yes	No
Are your teeth crowded or crooked?	Yes	No
Do you have existing dental work that you consider "ugly"?	Yes	No
Are you self-conscious of your teeth/ or smile?	Yes	No
Would you like to improve your existing smile?	Yes	No

Are you nervous when coming to the dentist? No Some Extremely

If you could change one thing about your smile/teeth- What would it be? _____

_____

Comments: _____

_____

*** FOR STAFF USE ONLY: ***
