Esthetic Evaluation

Dr. David D. Sims, DDS 120 NY Avenue
Huntington NY 11703
(631) 549-4055
www.davidsimsdds.com

To aid in our diagnosis and treatment of your esthetic concerns, please take a moment and answer the following questions. Please circle your answers.

If you are completely satisfied with the appearance of your teeth and smile there is no need to fill out this form.

Name:_____ **Date:**_____

1. Do you dislike the color of your teeth? ..... YES or NO
2. Do you have spaces between your teeth that bother you? ..... YES or NO
3. Do you have chips or uneven edges on your teeth? ..... YES or NO
4. Do you feel your teeth are too long or too short? ..... YES or NO
5. Do you have dark fillings that show when you smile? ..... YES or NO
6. Do your gums show too much when you smile? ..... YES or NO
7. Are your teeth too crowded or crooked? ..... YES or NO
8. Do you have existing crowns or dental work that you consider ugly? ..... YES or NO
9. Are you self-conscious of your teeth and/or smile? ..... YES or NO
10. Has anyone (friend, family member, etc) ever suggested that you should do something about your teeth or smile? ..... YES or NO
11. Do you avoid smiling when you have your picture taken? ..... YES or NO
12. Would you like to improve your existing smile? ..... YES or NO
13. Do you wish you had a “new smile”? ..... YES or NO

What concerns do you have regarding dental treatment to improve your smile?
(Please circle #)

1. Fear of treatment
2. Time of treatment concerns
3. Financial Concerns
4. Distance to office
5. Not understanding treatment
6. Embarrassment
7. Other

Thanks!