BERSON DENTAL HEALTH CARE

"Highest quality dentistry with the softest touch"

Personalized Esthetic Evaluation

*Name*____________________________________ *Age* _______ *Date*_______
Chief Complaint ____

Please answer the following questions that are specifically designed to aid our diagnosis and treatment of your smile:

1. *What would you say are your best facial features, e.g. eyes, nose, hair, etc.?*_________
____
2. *How would you describe your lips? Full, average, thin, etc.* ____________________
____
3. *If your smile were improved would you feel more confident?* ....Yes___No___
4. *Do you like the color of your teeth?* ....Yes___No___ Too dark?___Too varied?___
5. *Do your gums show when you are smiling?* ....A little?___ Average?___ A lot? ___
6. *How many upper teeth do you see when you are smiling?* ....# of teeth___
7. *Do you have spaces between your teeth?* ....Yes___No___
8. *Do these spaces bother you?* ....Yes___No___
9. *Does the color of your teeth bother you?* ....Yes___No___
10. *Does the shape of your teeth bother you?* ....Yes___No___
11. *Do you have chips or uneven edges on your teeth?* ....Yes___No___
12. *Do you feel that your teeth are too crowded?* ....Yes___No___
13. *Are your teeth "notched" at the gum line?* ....Yes___No___
14. *Do your gums feel and look healthy?* ....Yes___No___
15. *Are your teeth too short?* ....Yes___No___
16. *Are your teeth too long?* ....Yes___No___
17. *How long has your smile been bothering you?* ....Yes___No___
18. *Have you ever had orthodontic treatment?* ....Yes___No___
19. *Would you consider braces as an option to change your smile?* ....Yes___No___
20. *In general, how do you feel about your smile?* __________________________
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