WILLOWS
DENTAL PRACTICE

Smile Assessment Form

Name…….. Date ……

We would like to help you obtain the smile you've always wanted, so please take a few minutes to complete this short questionnaire. This will help our team to assist you in your journey to a healthy, happy, confident smile

		Yes	No
1	I am concerned about the appearance of my teeth or my smile.		
2	If I could I would like to change the colour of my teeth		
3	I am concerned about the shape of one or more of my teeth.		
4	In social situations, I sometimes feel self-conscious by my teeth or my smile.		
5	If I could I would like to change the appearance of my upper front teeth		
6	If I could I would like to change the appearance of my lower front teeth		
7	I have old fillings or previous dental treatment I would like to change/update		
8	I am missing one or more of my teeth		
9	I am interested in learning more about aesthetic dentistry.		
10	I cannot eat or chew the food I used to enjoy		

Please use the space below if you have any other concerns or questions. We will make every effort to listen to your concerns and provide the best possible treatment options