

It is our goal to offer solutions that are in alignment with what is most important to you. Your smile is an important aspect of your appearance and how you present yourself.

Is there anything you have ever wished to be different about your mouth, teeth, or smile?

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Do any of the following concern you when it comes to dental health?

- |  | YES                      | NO                       |
|--|--------------------------|--------------------------|
| Do you like the way your teeth look?   | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have spaces between your teeth that you would like to see closed?         | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have silver fillings that you wish were tooth-colored?                    | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you ever feel a better smile will give you more confidence?                   | <input type="checkbox"/> | <input type="checkbox"/> |
| Is it important to you to look younger?  | <input type="checkbox"/> | <input type="checkbox"/> |
| Are any of your teeth chipped?   | <input type="checkbox"/> | <input type="checkbox"/> |
| Are you interested in avoiding dentures and keeping your natural teeth for life? | <input type="checkbox"/> | <input type="checkbox"/> |
| Are your teeth too long or too short?  | <input type="checkbox"/> | <input type="checkbox"/> |
| Are you missing any teeth? If so are you interested in replacing them?           | <input type="checkbox"/> | <input type="checkbox"/> |
| Do any of your teeth appear to be yellow, discolored, or stained?                | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you wish your teeth were brighter or whiter?                                  | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have any crooked, misaligned, crowded, or uneven teeth?                   | <input type="checkbox"/> | <input type="checkbox"/> |

- |   | YES                      | NO                       |
|---|--------------------------|--------------------------|
| Would you like your teeth to be straighter?                                       | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have any dental crowns or bridges that look dark at the edge of your gums? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do your gums show too much when you smile?  | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you ever feel self-conscious about your teeth when you smile or laugh?         | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you ever find yourself covering your mouth when you laugh or smile?            | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you avoid smiling when you have your picture taken?                            | <input type="checkbox"/> | <input type="checkbox"/> |
| Has anyone ever suggested that you have something done with your teeth or smile?  | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you wish you had a "new smile"?  | <input type="checkbox"/> | <input type="checkbox"/> |
| Fear of dental treatment?   | <input type="checkbox"/> | <input type="checkbox"/> |
| Amount of time required away from work?   | <input type="checkbox"/> | <input type="checkbox"/> |
| Financial Concerns?   | <input type="checkbox"/> | <input type="checkbox"/> |
| Not understanding benefits or risk of treatment?                                  | <input type="checkbox"/> | <input type="checkbox"/> |
| Embarrassment about condition of teeth?   | <input type="checkbox"/> | <input type="checkbox"/> |
| Other?  | <input type="checkbox"/> | <input type="checkbox"/> |

Explain: \_\_\_\_\_  
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