Dr. Perkins
Esthetic Evaluation

Name _____ Date _____

Hold a full face mirror 12-14" from you face. Smile to show your teeth. Take a look at your teeth carefully, then answer the following questions.

Do you like the overall appearance of your teeth, your smile? [ ] Yes [ ] No
If NO, please describe_____

Do you consider that your teeth are in good alignment (straight)? [ ] Yes [ ] No
If NO, please describe_____

Do you have spaces between your teeth that you don't like? [ ] Yes [ ] No
If YES, please describe_____

Do you like the color of your teeth? [ ] Yes [ ] No

Are you interested in teeth whitening? [ ] Yes [ ] No

Do your teeth have unattractive stains? [ ] Yes [ ] No

[ ] Tobacco stains	[ ] Silver filling stains	[ ] Coffee / Tea stains
[ ] Discolored fillings	[ ] Tetracycline stains	[ ] Other _____

Do you like the shape of your teeth? [ ] Yes [ ] No
If NO, please describe_____

Do you think that your teeth are attractive? [ ] Yes [ ] No

[ ] Chipped	[ ] Hidden	[ ] Overlapping
[ ] Protruding	[ ] Excessively worn	[ ] Artificial looking

Do you like the way your upper and lower teeth come together? [ ] Yes [ ] No
If NO, please describe_____

Do you consider your existing fillings or dental work as unattractive?
If YES, please describe _____ [ ] Yes [ ] No

Do you think your gums are unattractive? [ ] Yes [ ] No

[ ] Swollen	[ ] Bleed easily	[ ] Excessively receded
[ ] Reddened	[ ] Crowns are ill-fitting	[ ] Difficult to clean between teeth

What would you like to change the most in the appearance of your teeth, your smile?_____

_____

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