

Hart Family Dental 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? _____

