

# Loudoun Dental Smiles

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## Smile Assessment

Your smile is important to us. So that we may better meet your expectations we'd like to know more about how YOU feel about your teeth. Consider each statement carefully and answer honestly. Our dental team will keep your responses confidential.

- |   |                           |                          |
|---|---------------------------|--------------------------|
| I am concerned about the appearance of my teeth or my smile.                      | <input type="radio"/> Yes | <input type="radio"/> No |
| I am concerned about the whiteness/lack of whiteness of my teeth.                 | <input type="radio"/> Yes | <input type="radio"/> No |
| I am concerned about the position or angle of some of my teeth.                   | <input type="radio"/> Yes | <input type="radio"/> No |
| I am concerned about the shape of my teeth.                                       | <input type="radio"/> Yes | <input type="radio"/> No |
| In social situations, I am sometimes embarrassed by my teeth or my smile.         | <input type="radio"/> Yes | <input type="radio"/> No |
| There are some things about my upper teeth that I would like to change.           | <input type="radio"/> Yes | <input type="radio"/> No |
| There are some things about my lower teeth that I would like to change.           | <input type="radio"/> Yes | <input type="radio"/> No |
| I have old fillings or previous dental work that is no longer satisfactory to me. | <input type="radio"/> Yes | <input type="radio"/> No |
| I am missing one or more of my teeth.   | <input type="radio"/> Yes | <input type="radio"/> No |
| I am interested in learning more about cosmetic dentistry.                        | <input type="radio"/> Yes | <input type="radio"/> No |

Do you have a specific concern that you would like to discuss with the dental team?

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Signature: \_\_\_\_\_ Date: \_\_\_\_\_