

ESTHETIC EVALUATION

Dr. Henry Herrmann & Dr. Joseph Desio
703.237.3131

To aid in our diagnosis and treatment of your esthetic concerns, please take a moment and answer the following questions. Please circle your answer. If you are completely satisfied with the appearance of your teeth and smile, there is no need to fill out this form.

Name: _____ Date: _____

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|--|--------|
| 1) Have you had braces? | YES/NO |
| 2) Are your teeth crowded or crooked | YES/NO |
| 3) If we could straighten your teeth with “invisible braces”, would | |
| 4) you be interested? | YES/NO |
| 5) Have you had any trauma to your teeth or mouth? | YES/NO |
| 6) Do you have spaces between your teeth that bother you? | YES/NO |
| 7) Are you self-conscious of your teeth and/or smile? | YES/NO |
| 8) Do you dislike the color of your teeth? | YES/NO |
| 9) Do you have chips or uneven edges on your teeth? | YES/NO |
| 10) Do you feel your teeth are too long or too short? | YES/NO |
| 11) Do you have dark fillings that show when you smile? | YES/NO |
| 12) Do your gums show too much when you smile? | YES/NO |
| 13) Do you have existing crowns or dental work you consider “ugly” ? | YES/NO |
| 14) Has anyone (friend, family member) ever suggested you should do something about your teeth or smile? | YES/NO |
| 15) Do you avoid smiling when you have your picture taken? | YES/NO |
| 16) Would you like to improve your smile? | YES/NO |
| 17) Do you wish you had a “new smile”? | YES/NO |

What concerns do you have regarding dental treatment to achieve a beautiful, healthy smile?

- 1) Fear of treatment?
- 2) Length of treatment?
- 3) Financial Concerns?
- 4) Distance to office?
- 5) Not understanding treatment?
- 6) Embarrassment?
- 7) Other?

Please add any additional information you wish Dr. Herrmann or Dr. Desio to know about your concerns: