Cosmetic Dentistry Smile Assessment Form

Full Name

Email Address

Phone Number

Smile Concerns

- [ ] Whiteness of teeth
- [ ] Alignment/crooked teeth
- [ ] Gaps between teeth
- [ ] Chipped/Broken teeth
- [ ] Teeth length or shape
- [ ] Gummy smile
- [ ] Other

Please describe your smile concerns

What would you like to improve about your smile?

Have you had any cosmetic dental treatments before?

- ( ) Yes
- ( ) No

If yes, please specify the treatments

What is your main goal or motivation for seeking cosmetic dental treatment?

How soon would you like to start your treatment?

Additional Questions or Comments