

**MARLAYNA C BEST DMD, LLC
NEWTON & ANDOVER, NJ
bestdentalnj.com**

SMILE ASSESSMENT FORM

Please consider each statement carefully and circle YES or NO. The doctor and team members will be happy to discuss your responses with you in confidence.

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| 1. I have concerns about the appearance of my teeth or my smile. | YES | NO |
| 2. I have concerns about the whiteness/lack of whiteness of one or more of my teeth. | YES | NO |
| 3. I have concerns about the position or angle of one or more of my teeth. | YES | NO |
| 4. I have concerns about the shape of one or more of my teeth. | YES | NO |
| 5. I am sometimes embarrassed by my teeth or my smile in social situations. | YES | NO |
| 6. There are some things about my upper front teeth that I would like to change. | YES | NO |
| 7. There are some things about my lower front teeth that I would like to change. | YES | NO |
| 8. I have old fillings or previous dental treatment that is no longer satisfactory to me. | YES | NO |
| 9. I am missing one or more of my teeth. | YES | NO |
| 10. I often cannot eat or chew the food that I used to enjoy. | YES | NO |