New Patient Evaluation

To aid in our diagnosis and treatment of your esthetic concerns, please take a moment and answer the following questions. Please circle your answer.

Do you like the appearance of your teeth and/or your smile?	Yes	No
Is there anything you would like to change about the appearance of your teeth? If YES, please explain_______________________________________	Yes	No
Do you like the color of your teeth?	Yes	No
Do you like the shape of your teeth?	Yes	No
Do you have any teeth that are chipped, uneven, protruding and/or hidden?	Yes	No
Are your teeth crowded or crooked?	Yes	No
Do your teeth appear to be flat or worn?	Yes	No
Do you have spaces between your teeth that bother you?	Yes	No
Do you have any missing teeth you would like to replace?	Yes	No
Do you have any existing dental work you are unhappy with?	Yes	No

Place a checkmark next to which of the following apply to you.

- ❑ Fear of treatment
- ❑ Time of treatment concerns
- ❑ Financial concerns
- ❑ Not understanding treatment
- ❑ Embarrassment
- ❑ Other____________________________________

How did you hear about our office? ____

***Patient Name*____*Date*______________________**

5115 Clinton Highway
Knoxville, TN 37912
(865)689-7556