

STEVEN A LEBEAU, DDS, FAGD  
6707 OLD DOMINION DRIVE SUITE 240  
MCLEAN, VA 22101  
(703) 734-2750

## ESTHETIC 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. If you are completely satisfied with the appearance of your teeth and smile, there is no need to fill out this form.

Name: \_\_\_\_\_ Date: \_\_\_\_\_

- |   |     |    |
|---|-----|----|
| 1. Do you dislike the color of your teeth?  | YES | NO |
| 2. Do you have spaces between your teeth that bother you?   | YES | NO |
| 3. Do you have chips or uneven edges on your teeth?   | YES | NO |
| 4. Do you feel your teeth are too long or too short?  | YES | NO |
| 5. Do you have dark fillings that show when you smile?  | YES | NO |
| 6. Do your gums show too much when you smile?   | YES | NO |
| 7. Are your teeth too crowded or crooked?   | YES | NO |
| 8. Do you have existing crowns or dental work you consider ugly?  | YES | NO |
| 9. Are you self-conscious about your teeth and/or your smile?   | YES | NO |
| 10. Has anyone (friends, family member, etc.) ever suggested that you do something about your teeth or smile? | YES | NO |
| 11. Do you avoid smiling when you have your picture taken?  | YES | NO |
| 12. Would you like to improve your existing smile?  | YES | NO |
| 13. Do you wish you had a "new smile"?  | YES | NO |

What concerns do you have regarding dental treatment to improve your smile?

1. Fear of treatment.
2. Time of treatment concerns.
3. Financial concerns.
4. Distance to office.
5. Not understanding treatment.
6. Embarrassment.
7. Pain/discomfort
8. Other

**THANK YOU.**