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PERSONALIZED ESTHETIC EVALUATION

Date: _____

Name: _____ Age: _____

Please answer the following questions that are specifically designed to aid our diagnosis and treatment of your esthetic concerns.

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|-----|---|-----|----|
| 1. | Do you dislike the color of your teeth? | Yes | No |
| 2. | Do you have spaces between your teeth? | Yes | No |
| 3. | Do you have chips or uneven edges on your teeth? | Yes | No |
| 4. | Do you have any visible dark fillings? | Yes | No |
| 5. | Are your teeth too short? | Yes | No |
| 6. | Are your teeth too long? | Yes | No |
| 7. | Are your teeth too crowded? | Yes | No |
| 8. | Do your teeth feel "notched" at the gumline? | Yes | No |
| 9. | Do your gums show when you are smiling | Yes | No |
| 10. | Do your gums feel unhealthy? | Yes | No |
| 11. | Do your gums feel irregular in contour? | Yes | No |
| 12. | Have you ever had orthodontic treatment? | Yes | No |
| 13. | Are you satisfied with your facial appearance? | Yes | No |
| | If not, why? _____ | | |
| 14. | If your smile were improved, would you feel more satisfied? | Yes | No |
| 15. | In general, how would you improve your smile? _____ | | |
