Your Personal Smile Evaluation

Name: _____ *Today's Date:* _____

When you see a picture of yourself or look into the mirror:

1. Are you pleased with the appearance of your smile? Have you had thoughts of wanting to improve?

2. Are your teeth noticeably stained, yellow, or otherwise discolored?

3. When you smile, are you able to see any spaces or missing teeth?

4. When you smile can you see uneven, crooked, chipped or crowded teeth? Does this concern you?

5. Do you like the shape of your teeth?

6. Do you have spaces between your teeth which you find unattractive?

7. Are the edges of your upper or lower front teeth worn flat from excessive wear?

8. Do you consider any of your old fillings or dental work unattractive?

9. When you smile, do your teeth seem to tilt one way or the other?

10. When you smile, does gum recession make your teeth appear too long? If so, does this concern you?

11. When you smile, are your gum levels at the necks of your teeth noticeably irregular?

12. When you smile, does it seem like you show too much gum tissue in relation to the amount of tooth?

13. Are you embarrassed to smile when you have your picture taken?

14. Do you have a habit of covering your mouth with your hand when you laugh because you are not happy with the appearance of your smile?

Dr. Steinberg would be happy to schedule a personalized consultation appointment to confidentially discuss any concerns you have, and discuss the benefits and individualized options for you to have the enjoyment of a beautiful engaging smile!

We will also show you before and after cosmetic procedures he has completed on our patients which have changed their lives.