Print Form

ERIC L. FUGIER, D.D.S., D.S.O, N.D.

Aesthetic, Prosthetic, Implant and Laser Dentistry

Personalized Aesthetic Evaluation

Name _____ Date _____

Please answer the following questions that are specifically designed to aid our diagnosis and treatment of your appearance related wish list.

1. Do you like the appearance of your teeth, your smile? ☐ Yes ☐ No
   If not, explain

   _____

2. Are your teeth all in alignment (straight)? ☐ Yes ☐ No
   If not, explain

   _____

3. Do you have Spaces you don't like? ☐ Yes ☐ No
   If not, explain

   _____

4. Do you like the color of your teeth? ☐ Yes ☐ No
   If not, explain

   _____

5. Do you like the shape of your teeth? ☐ Yes ☐ No
   If not, explain

   _____

6. Are your teeth...

   chipped _____ protruding _____ hidden _____ discolored _____

7. Do you like the way your teeth come together? ☐ Yes ☐ No
   If not, explain

   _____

8. Are there old silver fillings or dental treatment that you don't like looking at? ☐ Yes ☐ No
   If yes, explain

   _____

9. What would you like to change the most in the appearance of your smile?

   _____

10. How would you like your smile to look?

    _____

Beverly Sunset Medical Building ▪ 9201 Sunset Blvd. ▪ Suite 901 ▪ Los Angeles CA 90069
Tel. (310) 859-1575 ▪ Fax. (310) 859-1017