James L. Gallagher, D.D.S.
3403 Rivers Edge Dr.
Kingwood TX 77339

Smile Evaluation Checklist

Name:_____ Date:_____

Hold a mirror 12-14" from your face and smile to show your teeth. 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 dislike the color of your teeth?	YES	NO
Do you have spaces between your teeth that bother you?	YES	NO
Do you have chips or uneven edges on your teeth?	YES	NO
Do you feel that your teeth are too long or too short?	YES	NO
Do you have dark fillings that show when you smile?	YES	NO
Do your gums show too much when you smile?	YES	NO
Are your teeth crowded or crooked?	YES	NO
Do you have existing crowns or dental work that you consider "ugly"?	YES	NO
Are you self-conscious of your teeth and/or smile?	YES	NO
Has anyone (family member, friend, etc.) ever suggested that you should have something done with your teeth or smile?	YES	NO
Do you avoid smiling when you have your picture taken?	YES	NO
Would you like to improve your existing smile?	YES	NO
Do you wish you had a "new smile"?	YES	NO

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

_____ Fear of treatment
_____ Time of treatment concerns
_____ Not understanding treatment
_____ Financial concerns
_____ Distance to office
_____ Embarrassment
_____ Other