JANA BOYD DDS

Smile Assessment Form

First name:
Date of Birth:
Home phone:

Please consider these statements carefully and circle your response:

I'm concerned about the appearance of my teeth or my smile	YES	NO
I'm concerned about the whiteness of one or more of my teeth	YES	NO
I'm concerned about the straightness of one or more of my teeth	YES	NO
I'm concerned about the shape of one or more of my teeth	YES	NO
I have old fillings and would like to replace them with white fillings	YES	NO
I have had previous dental treatment that is no longer satisfactory	YES	NO

Please use space below to write anything you would like to discuss with your dental healthcare provider:

Kindly note your answers are confidential and for your dentist's information only.

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