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ERIC JOHNSON, DDS
AESTHETIC, IMPLANT & GENERAL DENTISTRY

Personalized Aesthetic Evaluation

_____ _____
Name Date

The questions below are specifically designed to aid our diagnosis and treatment of your smile-related concerns. Please consider them carefully and answer to the best of your ability.

Do you like the appearance of your teeth and your smile? ___ Yes ___ No

Do you like the color of your teeth? ___ Yes ___No

Does the shape of your teeth bother you? ___ Yes ___No

Do you have chips or uneven edges on your teeth? ___ Yes ___No

Do you feel that your teeth are too crowded? ___Yes ___No

Do your gums look and feel healthy? ___ Yes ___No

Is your bite comfortable? ___ Yes ___No

Would you like your teeth to be whiter & straighter? ___ Yes ___No

Are there any old silver fillings that you would like to have replaced? ___ Yes ___No

In general, how do you feel about your smile? Please list any other concerns you would like to discuss with us.

_____

_____

_____

_____

Thank you for completing this questionnaire!
We would like to help you obtain the smile of your dreams!

Eric Johnson, DDS and Team

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