Tri-Cities Center for
Cosmetic Dentistry
KATHY S. SANDERS, DMD, FAACD

Patient Name _____ Date _____

American Academy of Cosmetic Dentistry®
ACCREDITED FELLOW

Smile Analysis

Our practice is committed to excellence in appearance-related dentistry. In our efforts to construct for you the best smile design, *communication is the first and the most important step*. Please answer the following questions to help pinpoint areas of greatest concern.

Do you have concerns about? (Please check all that apply)

_____ Gaps or Spaces between Teeth

_____ Color of Teeth

_____ Shape of Teeth or Size of Teeth

_____ Show too much Gum

_____ Inflamed or Bleeding Gums

_____ Symmetry of Teeth

_____ Position of Teeth (crooked or crowded)

_____ Teeth Chipped or Broken

_____ Discolored Restorations (i.e. existing crowns, fillings, bonding) ___front teeth and/or ___back teeth

_____ Maintain Dental Health

Office Use:_____

What do you like best about your smile? _____

What do you like least about your smile? _____

What are your goals for your mouth?_____

Describe any previous cosmetic treatment:_____