Cleona Dental, LLC
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Cleona, PA 17042
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Redesign Your Smile

Patient Name:_____ Date:_____

To aid in our diagnosis and treatment of your esthetic concerns, please take a moment and answer these brief questions. Please circle your answers. Thank You!

1.	Do you dislike the color of your teeth?	Yes	No
2.	Do you have spaces between your teeth that bother you?	Yes	No
3.	Do you have chips or uneven edges on your teeth?	Yes	No
4.	Do you feel your teeth are too long or too short?	Yes	No
5.	Do you have dark fillings that show when you smile?	Yes	No
6.	Do your gums show too much when you smile?	Yes	No
7.	Are your teeth too crowded or crooked?	Yes	No
8.	Do you have existing crowns or dental work you consider "ugly"?	Yes	No
9.	Are you self-conscious of your teeth and/or smile?	Yes	No
10.	Has anyone (friend, family member, etc) ever suggested that you should do something about your teeth or smile?	Yes	No
11.	Do you avoid smiling when you have your picture taken?	Yes	No
12.	Would you like to improve your existing smile?	Yes	No
13.	Do you wish you had a "new smile"?	Yes	No

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

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

Other _____

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