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Patient Smile Assessment

*Evaluate
 your
 Smile!*

*Call us
 for a
 smile
 consult!*

	Circle Answer	
	Yes	No
Do you like to smile wide enough to show your teeth?	Yes	No
Are you happy with the way your teeth look?	Yes	No
Do you like the look of your crowns and fillings?	Yes	No
Are you satisfied with the whiteness of your teeth?	Yes	No
Are your teeth too long? Too short?	Yes	No
Do you brush your teeth very hard?	Yes	No
Are you missing teeth?	Yes	No
Are you interested in improving the appearance of your teeth?	Yes	No
Are you familiar with the benefits of implants?	Yes	No
Do your teeth or gums hurt?	Yes	No
Are you anxious or fearful of treatment?	Yes	No
Are you interested in esthetic (cosmetic) dentistry?	Yes	No
Would you like to learn more about modern cosmetic procedures?	Yes	No
If you could change something about your smile, what would it be?		

Name _____ Date _____