

STRATEGIC ESTHETIC PLANNING GUIDE

Name: _____ Age _____ Date: _____

1. PATIENT SMILE CONCERNS

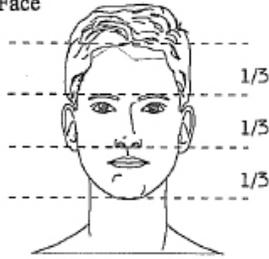
- 1) What are their expectations of their dental care?
- 2) How is their dentistry/smile affecting their life?
- 3) Family, Occupation, and Recreation (FIT)?
- 4) Are they self-conscious about smiling? For how long?
- 5) Do they ever put their hand over their mouth?
- 6) Do they photograph better on one side of their face?
- 7) Is there someone they believe has a better smile?
- 8) Do they look at magazines and wish they had a smile like a specific person?
- 9) When they look in the mirror, what defects do they see?
- 10) What do they rate their smile from 1—2—3—4—5—6—7—8—9—10?
- 11) Do they wish their teeth were whiter?
- 12) Are there any white or brown stains?
- 13) Are their teeth too square or round?
- 14) Do they like the way their teeth are shaped?
- 15) Are the teeth too wide or uneven in length?
- 16) Are their teeth too short or too long?
- 17) Do the front teeth protrude or stick out?
- 18) Is there a space between the front teeth?
- 19) Are the front teeth crowded or overlapping?
- 20) Are the front teeth straight?
- 21) Habits
 - Bruxism Clenching Mouth Breathing Post-Treatment Occlusal Guard
 - Smoking P.P.D. _____ Number of Years _____

2. PHOTOGRAPHY (CAED Guidelines)

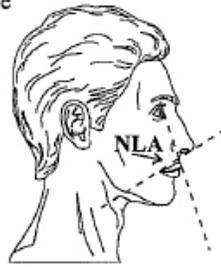
- | | | |
|---------------------------------------|--|--|
| <input type="checkbox"/> Full Face | <input type="checkbox"/> Right Lateral | <input type="checkbox"/> Smile Retracted |
| <input type="checkbox"/> Smile Shot | <input type="checkbox"/> Lower Arch | <input type="checkbox"/> Right Lateral Retracted |
| <input type="checkbox"/> Left Lateral | <input type="checkbox"/> Upper Arch | <input type="checkbox"/> Left Lateral Retracted |

3. FACIAL EVALUATION

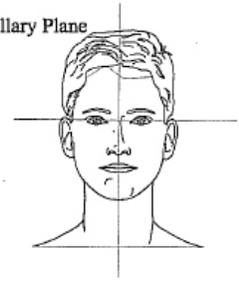
Full Face



Profile



Interpupillary Plane



a. Overall Evaluation

1/3 rule (within normal limits)

Yes No

Symmetry of right and left sides

Yes No

b. Facial Outline (Trubyte® Tooth Indicator required)

Square

Tapering

Square Tapering

Ovoid

c. Nasal Labial Angle (N.L.A.)

♂ 90° - 95°,

♀ 100° - 105°

Acute

W.N.L.

Obtuse

d. Facial Profile

Straight (W.N.L.)

Convex

Concave

e. Maxillary Canting

Interpupillary Plane parallel with the horizon?

Yes No

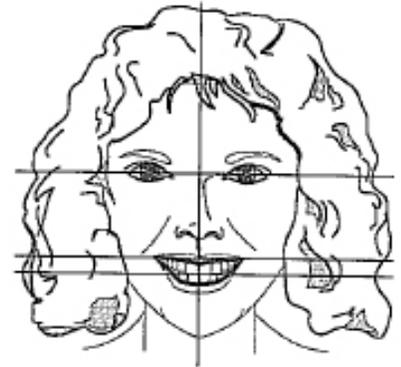
Interpupillary Plane coincident with the Incisal Plane?

Yes No

Interpupillary Plane coincident with the Occlusal Plane?

Yes No

f. Plastic/Oral Surgery recommendations



4. SMILE EVALUATION

a. Lip Type

Full

Average

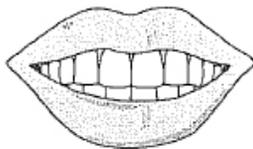
Thin

b. Lips at Rest

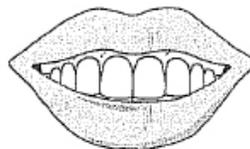
Together

Apart _____ mm

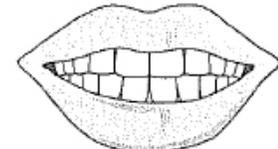
c. Upper Lip to Central Incisors in Full Smile



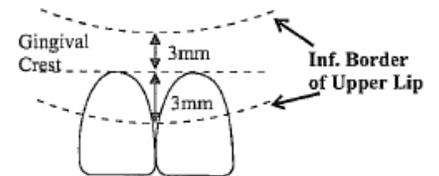
Average



High



Low



d. Number of Teeth Revealed at Full Smile/Buccal Corridor



Six



Eight



Ten



Twelve

e. Extent of Lower Teeth Revealed.

7. RESTORATIVE EVALUATION:

B.

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
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P.

18	17	16	15	14	13	12	11	21	22	23	24	25	26	27	28
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L.

48	47	46	45	44	43	42	41	31	32	33	34	35	36	37	38
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B.

32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17
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a) Record all existing restorations, caries, rotations, attrition, and discolourations.

b) Record periodontal pocket depths, mobility, and recession.

c) Record non-inflammatory periodontal defects, such as gingival clefts, blunted papillae, ridge defects, and gingival asymmetries.

8. PERIODONTAL EVALUATION

Periodontal Case Type: Health Gingivitis Mild Moderate Severe

DIAGNOSTIC AIDS REQUIRED:

- | | |
|---|---|
| <input type="checkbox"/> Diagnostic Study Models | <input type="checkbox"/> Computer Imaging |
| <input type="checkbox"/> Specialist Communication | <input type="checkbox"/> Radiographic Evaluation |
| <input type="checkbox"/> Diagnostic Wax Up | <input type="checkbox"/> Photography Release Form |

CASE PRESENTATION NOTES:
