

SMILE EVALUATION

Name _____ Date _____

1. Do you like the way your teeth look? Yes _____ No _____

Explain: _____

2. Are you happy with the color of your teeth? Yes _____ No _____

Explain: _____

3. Would you like for your teeth to be whiter? Yes _____ No _____

Explain: _____

4. Would you like your teeth to be straighter? Yes _____ No _____

Explain: _____

5. Do you have spaces between your teeth that you would like closed? Yes ___ No ___

Explain: _____

6. Would you like your teeth to be longer? If so, Upper ___ Lower ___ Both ___

Explain: _____

7. Do you like the shape of your teeth? Yes _____ No _____

Explain: _____

8. Do you have missing teeth that you would like replaced? Yes _____ No _____

Explain: _____

9. Do you have old silver fillings that you would like replaced with tooth colored fillings? Yes _____ No _____

Explain: _____

10. If you could change anything about your smile, what would you change?
