Smile Evaluation

Name:

1.Do you like the appearance of your teeth, your smile.? Yes____ No____

If not, Please explain: ____

2.Are your teeth all in alignment (Straight)? Yes____ No____

If not, Please explain: ____

3.Do you have spaces that you don't like? Yes____ No____

If yes, Please explain: ____

4.Do you like the color of your teeth? Yes____ No____

If not, Please explain: ____

5.Do you like the shape of your teeth? Yes____ No____

If not, Please explain: ____

6.Are your teeth...? Chipped____ Protruding ____ Hidden ____

7.Do you like the way your teeth come together? Yes____ No____

If not, Please explain: ____

8.Are there old fillings or dental work that you don't like looking at? Yes____ No____

If yes, Please explain: ____

9.What would you like to change the most in the appearance of your teeth?

Please explain: ____

10.How would you like your teeth to look?

Please explain: ____