SMILE EVALUATION

PATIENT NAME: ______________________________________ **DATE:** ________________

1. Do you like the appearance of your teeth and smile? ____ Yes ____ No

If not, explain____

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2. Are your teeth all in alignment (straight)? ____ Yes ____ No

3. Do you like the way your teeth come together? ____ Yes ____ No

If not, explain____

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4. Do you have spaces that you don't like? ____ Yes ____ No

If yes, explain____

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5. Do you like the color of your teeth? ____ Yes ____ No

If not, explain____

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6. Do you like the shape of your teeth? ____ Yes ____ No

If not, explain____

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7. Are there old fillings or dental work that you don't like looking at? ____ Yes ____ No

If not, explain____

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8. Are you missing any of your teeth? ____ Yes ____ No

9. Do the teeth look short, worn, or flat? ____ Yes ____ No