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: ____