

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 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 close? Yes No

If so, where? _____

6. Would you like your teeth to be longer? Yes No

If so, Upper _____, Lower _____, Both _____?

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

Explain: _____

8. Do you have missing teeth that you would like to replace? Yes No

Explain: _____

9. Do you have old Silver fillings that you would like to replace with tooth-colored fillings? Yes No

Explain: _____

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