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
   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 you would like to replace? ☐Yes ☐No
   Explain:_____

9) Do you have stained fillings you would like replaced?
   ☐Yes ☐No
   Explain:_____

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

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