

Patient Name: _____

Date: ____/____/____

SMILE EVALUATION

Please take a few moments to complete the following questionnaire so we may help you to achieve the smile you have always wanted! Hold a face mirror 12" – 14" from your face. Smile to show your teeth; take the time to observe your teeth carefully and then answer the questions.

1. Do you like the appearance of your teeth, your smile? Yes No
If not, explain _____

2. Are your teeth all in alignment (straight)? Yes No
If not, explain _____

3. Do you have spaces that you don't like? Yes No
If yes, explain _____

4. Do you like the color of your teeth? Yes No
If not, explain _____

5. Do you like the shape of your teeth? Yes No
If not, explain _____

6. Are your teeth... Chipped Protruding Hidden
7. Do you like the way your teeth come together? Yes No
If not, explain _____

8. Are there old fillings or dental work that you don't like looking at? Yes No
If yes, explain _____

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

