Smile Evaluation

Name:_____ Date:_____

1. Do you like the way your teeth look? Yes □ No □

2. Are you happy with the color of your teeth? Yes □ No □

3. Would you like for your teeth to be whiter? Yes □ No □

4. Would you like your teeth to be straighter? Yes □ No □

5. Do spaces between your teeth bother you? Yes □ No □

If so, where? _____

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

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

Explain: _____

8. Would you like to replace missing teeth? Yes □ No □

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? _____