

# SMILE EVALUATION

Questions to help you obtain the smile you have always wanted

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Look at yourself in a mirror. Smile to show your teeth, and take the time to observe them carefully... then answer the following questions.

**Do you like the appearance of your teeth?** Yes \_\_\_\_\_ No \_\_\_\_\_

If not, please explain: \_\_\_\_\_  
\_\_\_\_\_

**Do you like the color of your teeth?** Yes \_\_\_\_\_ No \_\_\_\_\_

If not, please explain: \_\_\_\_\_  
\_\_\_\_\_

**Are your teeth in alignment?** Yes \_\_\_\_\_ No \_\_\_\_\_

If not, please explain: \_\_\_\_\_  
\_\_\_\_\_

**Do you have spaces you don't like?** Yes \_\_\_\_\_ No \_\_\_\_\_

If not, please explain: \_\_\_\_\_  
\_\_\_\_\_

**Do you like the shape of your teeth?** Yes \_\_\_\_\_ No \_\_\_\_\_

If not, please explain: \_\_\_\_\_  
\_\_\_\_\_

**Are any of your teeth...**

Chipped \_\_\_\_\_ Protruding \_\_\_\_\_ Hidden \_\_\_\_\_ Where: \_\_\_\_\_

**Do you like the way your teeth come together?** Yes \_\_\_\_\_ No \_\_\_\_\_

If not, please explain: \_\_\_\_\_  
\_\_\_\_\_

**Are there old fillings or dental work that you don't like looking at?** Yes \_\_\_\_\_ No \_\_\_\_\_

If not, please explain: \_\_\_\_\_  
\_\_\_\_\_

**What would you like to change the most about your teeth?**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_