

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

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

## Smile Evaluation

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

Explain: \_\_\_\_\_

6. Do you have spaces between your teeth that you would like closed? Yes  No

Explain: \_\_\_\_\_

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

Explain: \_\_\_\_\_

8. Do you have old fillings that you would like to replace? Yes  No

Explain: \_\_\_\_\_

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

\_\_\_\_\_  
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