SMILE EVALUATION

NAME: _____ **DATE:** _____

We would like to help you obtain the smile you've always wanted. Please take a few minutes to complete this short questionnaire. While using a mirror or looking at a photograph, please observe your teeth carefully.

		YES	NO
1)	Are you pleased with the appearance of your teeth when you smile?	❑	❑
2)	Do you have spaces between your teeth?	❑	❑
3)	Do these spaces bother you?	❑	❑
4)	Do you like the color of your teeth? ❑ Too Dark ❑ Too Varied	❑	❑
5)	Would you like your teeth to be whiter?	❑	❑
6)	Do you have chips or uneven edges on your teeth?	❑	❑
7)	Do your gums show when you are smiling? ❑ A little ❑ Average ❑ A lot		
8)	Do you have stained or discolored teeth or fillings?	❑	❑
9)	Does the shape of your teeth bother you?	❑	❑
10)	Are any of your teeth crowded, overlapping, or crooked?	❑	❑
11)	Do you like the way your teeth fit together when you bite?	❑	❑
12)	Do you wish your teeth were ❑ Longer ❑ Shorter		
13)	Are there old fillings or dental treatment that you aren't happy with? If yes, what area(s)? _____	❑	❑
14)	Are any of your teeth "notched" or sensitive at the gum line?	❑	❑
15)	Do your teeth seem out of proportion because they are uneven in length?	❑	❑
16)	Do your gums feel and look healthy?	❑	❑
17)	If you could change anything about the appearance of your smile, what would that be? _____		

Comments _____