

## Smile Evaluation

Name \_\_\_\_\_ Date \_\_\_\_\_

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. Do you have spaces between your teeth that you would like closed? Yes  No   
If so, where? \_\_\_\_\_
6. Would you like your teeth to be longer? Yes  No   
If so, Upper \_\_\_\_\_ Lower \_\_\_\_\_ Both \_\_\_\_\_
7. Do you like the shape of your teeth? Yes  No   
Explain: \_\_\_\_\_
8. Do you have missing teeth that you would like to replace? Yes  No   
Explain: \_\_\_\_\_
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?

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