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SMILE ASSESSMENT

1. Are you happy with your smile? Yes / No

Comments:

2. Would you like your smile to be whiter? Yes / No

Comments:

3. What do you like about your smile?

4. What don't you like, if anything, about your smile?

5. On a scale of 1 to 10, how would you rate your smile?

Poor 1 2 3 4 5 6 7 8 9 10 Great

Patient Name _____ Date_____