Smile Evaluation

1) Are there old fillings or other dental work that you don't like looking at? ..... Yes ☐ No ☐
   If so, please explain_____

2) Do you like the color of your teeth? ..... Yes ☐ No ☐
   If not, please explain_____

3) Do you like the alignment (straightness) of your teeth? ..... Yes ☐ No ☐
   If not, please explain_____

4) Do you like the overall appearance of your teeth… and your smile? ..... Yes ☐ No ☐
   If not, explain_____

5) Do you have spaces that you don't like? ..... Yes ☐ No ☐
   If so, please explain_____

6) What would you <u>most</u> (if anything) like to change in the appearance of your teeth?
   _____

7) How would you like your teeth to look? _____