THE STUDIO

FOR EXCEPTIONAL DENTISTRY

SMILE EVALUATION

Patient's Name_____ **Date**_____

A simple questionnaire to help us create the SMILE you have always wanted!

1. Do you like the appearance of your teeth? ( ) Yes ( ) No
   of your smile? ( ) Yes ( ) No

If not, what would you like to change?_____

_____

2. Are your teeth straight? ( ) Yes ( ) No

If not, what changes would you make?_____

_____

3. Do you have spaces between your teeth that you are unhappy with? ( ) Yes ( )No

Where?_____

4. Do you like the color of your teeth? ( ) Yes ( ) No

5. Are you happy with the shape of your teeth? ( ) Yes ( ) No

If not, Why?_____

6. Are your teeth…….

Chipped?_____ Sticking Out?_____ Crowded?_____

7. Do you have any old fillings or crowns that you are unhappy with? ( ) Yes ( ) No

What would you change?_____

8. What would you like to change about the appearance of your teeth?

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