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Date

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**Smile Evaluation**

Patient First Name:

Last Name:

Middle Initial:

Do you like the appearance of your teeth? Yes No

Do you like the appearance of you smile? Yes No

If not, what would you change?

Are your teeth straight? Yes No

If not, what changes would you make?

Do you have spaces between your teeth  
you are unhappy with? Yes No

Where?

Do you like the color of your teeth? Yes No

Are you happy with the shape of your  
teeth? Yes No

If not why?

Are your teeth....? Chipped? Sticking Out? Crowded?

Do you have old crowns or fillings that you  
are unhappy with? Yes No

What would you change?

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