

PATRICIA DECILLA, D.D.S.

COSMETIC & GENERAL DENTISTRY

COSMETIC EVALUATION

Name: _____ Date: _____

	Yes	No
Do you like the appearance of your teeth?	<input type="radio"/>	<input type="radio"/>
Are your teeth as straight as you would like them to be?	<input type="radio"/>	<input type="radio"/>
Are you happy with the length, width, and shape of your teeth?	<input type="radio"/>	<input type="radio"/>
Do you have any missing teeth?	<input type="radio"/>	<input type="radio"/>
Do you have any chipped teeth?	<input type="radio"/>	<input type="radio"/>
Do you have any spaces between your teeth?	<input type="radio"/>	<input type="radio"/>
Do you have any discoloration or spots on you teeth?	<input type="radio"/>	<input type="radio"/>
Do you have any dental work that you don't like?	<input type="radio"/>	<input type="radio"/>
Would you like to have whiter teeth?	<input type="radio"/>	<input type="radio"/>
Do you have any silver fillings that you would like to have changed to white?	<input type="radio"/>	<input type="radio"/>
Are you aware of the new techniques in dentistry?	<input type="radio"/>	<input type="radio"/>

If there were anything you could change about the appearance of your teeth, what would it be?
