*Your Perfect Smile Cosmetic & Family Dentistry*
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# SMILE EVALUATION

**A Simple Quiz to Help You Obtain the Smile You've Always Wanted**

Patient Name: _____

1. Do you like the appearance of your teeth; your smile? ☐ Yes ☐ No
If not, explain _____
_____

2. Are your teeth all in alignment (straight)? ☐ Yes ☐ No
If not, explain _____
_____

3. Do you have spaces that you don't like? ☐ Yes ☐ No
If yes, explain _____
_____

4. Do you like the color of your teeth? ☐ Yes ☐ No
If not, explain _____
_____

5. Do you like the shape of your teeth? ☐ Yes ☐ No
If not, explain _____
_____

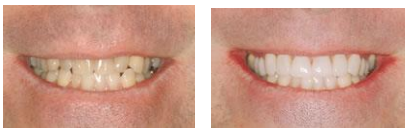
6. Are your teeth…
Chipped? _____ protruding?_____ hidden _____
_____

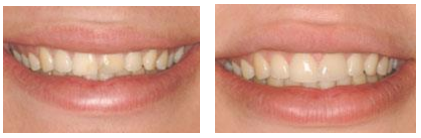
7. Are your teeth wearing on the biting surfaces? ☐ Yes ☐No
If yes, explain _____
_____

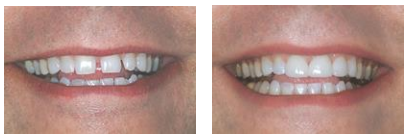
8. Are there old filling or dental work you don't like looking at? ☐ Yes ☐No
If yes, explain _____
_____

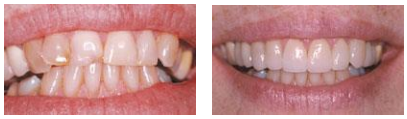
9. What would you like to change the most in the appearance of your teeth?
_____
_____

10. How would you like your teeth to look?
_____
_____
_____

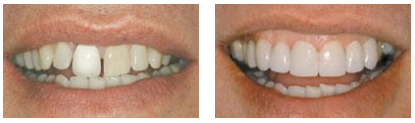

Stained Teeth


Chipped Teeth


Spaced Teeth


Crooked Teeth


Fanged Teeth


Renewing Old Dental Work

**If you are not happy with the appearance of your teeth, ask us how we can improve your smile.**

**YOUR SMILE IS THE EASIEST WAY TO IMPROVE YOUR APPEARANCE!**

**Your Smile is Our Business!**