# SMILE EVALUATION

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 fillings 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?