PERSONALIZED SMILE EVALUATION

Name_____ **Date** _____

Please answer the following questions that specifically designed to aid our diagnosis and treatment of your appearance related problem to give you the smile you have always wanted.

1. Do you like the appearance of your teeth, your smile? (yes) (no)
explain _____
_____

2. Are your teeth all in alignment (straight)? (yes) (no)
explain _____
_____

3. Do you have spaces you don't like? (yes) (no)
explain _____
_____

4. Do you like the color of your teeth? (yes) (no)
explain _____
_____

5. Do you like the shape of your teeth? (yes) (no)
explain _____
_____

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

7. Do you like the way your teeth come together (yes) (no)
If not explain _____
_____

8. Are there old silver fillings or dental treatments (yes) (no)
you don't like looking at?
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? _____