Family Dentistry

SMILE EVALUATION

1. Do you like the way your teeth look? Yes ☐ No ☐
2. Do you like your smile? Yes ☐ No ☐
3. Are you happy with the color of your teeth? Yes ☐ No ☐
4. Would you like for your teeth to be whiter? Yes ☐ No ☐
5. Would you like for your teeth to be straighter? Yes ☐ No ☐
6. Do you have spaces between your teeth that you would like closed? Yes ☐ No ☐
7. Would you like for your teeth to be longer or shorter? Yes ☐ No ☐
8. Do you like the shape of your teeth? Yes ☐ No ☐
9. Do you have missing teeth that you would like replaced? Yes ☐ No ☐
10. Are you pleased with the appearance of your existing dental work? Yes ☐ No ☐
11. Do you have old silver fillings that you don't like how they look Yes ☐ No ☐
12. Rate your smile on a scale of 1-10, with 10 being the highest. _____
13. What are your long term goals for your teeth? _____

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