

**Smile Evaluation** (circle Yes or No)

Name: \_\_\_\_\_ Date: \_\_\_\_\_

1. Do you like the way your teeth look?                      Yes                      No

Explain: \_\_\_\_\_

2. Are you happy with the color of your teeth?                      Yes                      No

Explain: \_\_\_\_\_

3. Would you like for your teeth to be whiter?                      Yes                      No

Explain: \_\_\_\_\_

4. Would you like your teeth straighter?                      Yes                      No

Explain: \_\_\_\_\_

5. Would you like your teeth to be longer?                      Yes                      No

Explain: \_\_\_\_\_

6. Do you like the shape of your teeth?                      Yes                      No

Explain: \_\_\_\_\_

7. Do you have spaces between your teeth that you would like closed?    Yes                      No

Explain: \_\_\_\_\_

8. Do you have missing teeth that you would like to replace?                      Yes                      No

Explain: \_\_\_\_\_

9. Do you have old silver fillings that you would like to replace with tooth-colored fillings?                      Yes                      No

Explain: \_\_\_\_\_

10. If you could change anything about your smile, what would you change?

\_\_\_\_\_