BARRINEAU D.D.S.
Family Dental Care & Wellness

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?

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