SMILE EVALUATION

We would like to help you obtain the smile you've always wanted. Please take a few minutes to complete this short questionnaire. While using a mirror or looking at a photograph, please observe your teeth carefully.

Do you have any concerns about **bad breath odor**? ☐ No

☐ Yes ____

Are you pleased with the **appearance** of your teeth when you smile? ☐ Yes

☐ No ____

Are you pleased with the **color** of your teeth? ☐ Yes

☐ No ____

Are you pleased with the **shape** of your teeth? ☐ Yes

☐ No ____

Are there **spaces** between your teeth that you don't like? ☐ No

☐ Yes ____

Are your teeth...

chipped?____ protruding?_____ hidden?_____ crowded?_____

Do you like the way your **teeth fit together** when you bite? ☐ Yes

☐ No____

Are there **old fillings** or dental treatment that you aren't happy with? ☐ No

☐ Yes____

If you could **change anything** about the appearance of your smile, what would that be?

____

Is there anything about the **shape or alignment** of your jaws that you are not happy with?

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