Smile Evaluation

1. Do you like the way your teeth look? Yes □ No □
   Explain: _____

2. Would you like your teeth to be straighter? Yes □ No □
   Explain: _____

3. Do you have spaces between your teeth that you would like closed?
   Yes □ No □
   Explain: _____

4. Have your teeth worn down? Yes □ No □
   If so, Upper ____ Lower ____ Both ____?

5. Do you like the shape of your teeth? Yes □ No □
   Explain: _____

6. Do you have missing teeth that you would like to replace?
   Yes □ No □
   Explain: _____

7. Do you have old silver fillings that you would like to replace with tooth-colored fillings? Yes □ No □
   Explain: _____

8. If you could change anything with your teeth and smile, what would you change?
   Explain: _____
   _____

Please return this form to our office, along with your health history and HIPAA acknowledgement prior to your visit, as this will help us to prepare better.

Thank you!