Personalized Smile Evaluation

A SIMPLE TWO MINUTE, 10 QUESTION QUIZ TO HELP YOU OBTAIN THE SMILE YOU HAVE ALWAYS WANTED

Name _____ Date _____

Please answer the following questions that are specifically designed to aid our diagnosis and treatment of your appearance related problem.

1. Do you like the appearance of your teeth, your smile? ⟨ ⟩ Yes ⟨ ⟩ No
   If not, explain _____
   _____

2. Are you teeth all in alignment (straight)? ⟨ ⟩ Yes ⟨ ⟩ No
   If not, explain _____
   _____

3. Do you have spaces you don't like? ⟨ ⟩ Yes ⟨ ⟩ No
   If yes, explain _____
   _____

4. Do you like the color of your teeth? ⟨ ⟩ Yes ⟨ ⟩ No
   If not, explain _____
   _____

5. Do you like the shape of your teeth? ⟨ ⟩ Yes ⟨ ⟩ No
   If not, explain _____
   _____

6. Are your teeth...
   chipped _____ protruding _____ hidden _____

7. Do you like the way your teeth come together? ⟨ ⟩ Yes ⟨ ⟩ No
   If not, explain _____
   _____

8. Are there old silver fillings or dental treatment that you don't like looking at? ⟨ ⟩ Yes ⟨ ⟩ No
   If yes, explain _____
   _____

9. What would you like to change the most in the appearance of your teeth? _____
   _____

10. How would you like your teeth to look? _____
    _____

We'd like to help you obtain that beautiful smile ...