

Personalized Smile Evaluation

Name: _____

Date: _____

In an effort to help you achieve maximum oral health and appearance, please take a moment to answer the following questions:

1. On a scale of 1 to 10, how do you feel about your teeth and smile? _____

2. Are your teeth crooked or crowded and is that a concern? *Please comment:*

3. Do you have any spaces between your teeth that bother you? _____

4. Do you like the color of your teeth? *Please comment:* _____

5. Do you like the shape of your teeth? *Please comment:* _____

6. What would you like to change about the appearance of your smile? _____

7. Have you ever considered how you might feel with a brighter smile?

Please comment: _____