SMILE ASSESSMENT

Name: ____________________________ Date: __________________________

1. Are there spaces between your teeth that bother you? Yes No
2. Do you have dark-colored fillings that show when you smile, and if so, is that a concern? Yes No
3. Do you think your teeth are too long or short? Yes No
4. Do you avoid smiling when you have pictures taken? Yes No
5. Do you wish your teeth were shaped differently? Yes No
6. Do you have missing teeth you would like replaced? Yes No
7. Do you have existing dental work you are no longer satisfied with? Yes No
8. Do you wish your teeth were whiter or a more consistent shade or color? Yes No
9. What would you change about your smile and teeth if you could?

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