



**ALL FAMILY DENTISTRY**

# Smile Evaluation

*All that is good begins with a smile*

1 How would you rate your smile from 1 to 10 (1-very unsatisfactory, 10-very satisfactory)

1 2 3 4 5 6 7 8 9 10

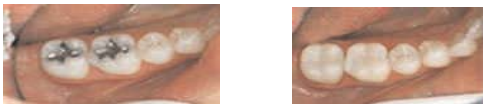
2 Would you like your teeth to be whiter? **YES** **NO**



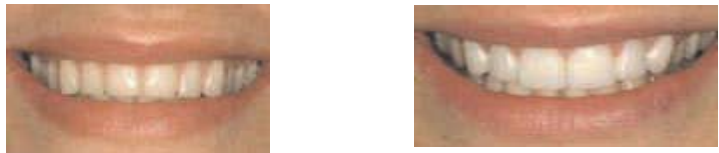
6 Do you have spaces between your teeth, you would like to close? **YES** **NO**



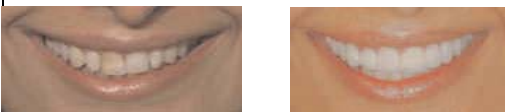
3 Are there old silver fillings or dental work you would like to replace? **YES** **NO**



7 Would you like to change the shape of your teeth ie; longer, rounder, etc....? **YES** **NO**



4 Would you like your teeth to be straighter? **YES** **NO**



8 Are any of your teeth chipped or worn? **YES** **NO**



5 Are there any missing teeth you would like to replace? **YES** **NO**



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

Explain \_\_\_\_\_

## COMMENTS

Print Name \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_