Forest City
DENTAL

SMILE EVALUATION

_____ _____

Patient Name Date

Do you like the appearance of your teeth?	___Yes ___No
Are your teeth all in alignment (straight)?	___Yes ___No
Do you have spaces?	___Yes ___No
Do you like the color of your teeth?	___Yes ___No
Do you wish your teeth were whiter?	___Yes ___No
Are your teeth chipped?	___Yes ___No
Are your teeth protruding?	___Yes ___No
Are your teeth hidden?	___Yes ___No
Are your teeth wearing on the biting surfaces?	___Yes ___No
Are there old crowns or fillings you don't like to look at?	___Yes ___No

What would you like your smile to look like?

_____

_____