



Smile Evaluation

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| ◆ Are you pleased and confident with the way your teeth look when you smile? | YES | NO |
| ◆ Do you have some unwanted spaces or gaps between your teeth? | YES | NO |
| ◆ Is there a chip or crack that you would like to have repaired? | YES | NO |
| ◆ Are you concerned about one or perhaps more than one tooth that is discolored? | YES | NO |
| ◆ Do you have any unattractive discolored metal or plastic fillings you want replaced?
(These can be either front or back teeth.) | YES | NO |
| ◆ Do you have teeth that are slightly out of line, overlapping or protruding? | YES | NO |
| ◆ How are your gums? | | |
| ○ Are they red and/or swollen? | YES | NO |
| ○ Have they receded from the top of your teeth? | YES | NO |
| ◆ Do you have any missing teeth that you would like to have replaced? | YES | NO |
| ◆ Are you interested in starting cosmetic work (i.e. Braces, Veneers, Lumineers)? | YES | NO |
| ◆ Could your smile be improved if your teeth were..... | | |
| Whiter | YES | NO |
| Longer | YES | NO |
| Shorter | YES | NO |
| Wider | YES | NO |
| Narrower | YES | NO |
| ◆ Is there anything else you would like to discuss with your dentist about your smile design or dental health? | | |
