## **Smile Evaluation**

Hold a full- face mirror 12"-14" from your face. Smile to show your teeth; take the time to observe your teeth carefully. Then answer the following questions. (It is helpful to have a friend ask you the questions)

			Dat	Date:	
Title	Last	First	Middle		
1.	Do you like the overall appearance of your teeth, your smile? If NO, please describe			□ Yes □ No	
2.	Do you consider to If NO, please des	that your teeth are in good scribe	d alignment (straight)?	□ Yes □ No	
3.	Do you have spaces between your teeth that you don't like? If YES, please describe		at you don't like?	□ Yes □ No	
4.	Do you like the color of your teeth? If NO, please describe			□ Yes □ No	
5.	Do your teeth have unattractive stains?  Circle: Tobacco stains, Coffee/tea stains, Discolored fillings  Tetracycline stains, Silver filling stains,  Other			□ Yes □ No	
6.	Do you like the shalf NO, please des	nape of your teeth? scribe		□ Yes □ No	
7.	Circle: Chipped,	your teeth are attractive? Overlapping, Protruding, Artificial looking		□ Yes □ No	
8.		ay that your upper and lov	wer teeth come together?	□ Yes □ No	
9.	Do you consider that your existing fillings or dental work is unattractive? $\hfill\square$ $Yes$ $\hfill\square$ $N$ If YES, please describe				
10.	Circle: Swollen,	your gums are unattractive Excessively receded, Recure ill-fitting, Bleed easily,		□ Yes □ No	
11.	On a scale of 1 to a 10?	o 10, how would you rate	your smile? What would	it take to make it	
12.	What would you I	ike to change the most in	the appearance of your te	eth, your smile?	