

Your Smile Evaluation

- | | Yes | No |
|---|--------------------------|--------------------------|
| 1. Are you pleased and confident with the way your teeth look when you smile? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Do you have some unwanted spaces or gaps between your teeth? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Is there a chip or crack that you would like to have repaired? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Are you concerned about one or perhaps more than one tooth that is discolored? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Maybe you have some unattractive discolored metal or plastic fillings?
(These can be either anterior/front or posterior/back teeth) | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Do you have teeth that are slightly out of line, overlapping, or protruding? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. How are your gums?
Are they red or swollen? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have they receded from the top of your teeth? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Do you have some missing teeth that should be replaced? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Could your smile be improved if your teeth were... Whiter? | <input type="checkbox"/> | <input type="checkbox"/> |
| Longer? | <input type="checkbox"/> | <input type="checkbox"/> |
| Shorter? | <input type="checkbox"/> | <input type="checkbox"/> |
| Wider? | <input type="checkbox"/> | <input type="checkbox"/> |
| Narrower? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Is there anything else you would like to discuss with your dentist about your smile design or dental health? | | |
