Smile Assessment

Welcome to our office! It is our policy to help give you the smile you have always wanted. One way we like to do this is by asking you what you think of your own smile! Please fill out the form below so that we may better serve your needs.

Do you feel uncomfortable or self-conscious about your smile? **Yes/No**

Do you cover your mouth when you talk or smile? **Yes/No**

Are your teeth in alignment (straight)? **Yes/No**

Do you wish your teeth were whiter? **Yes/No**

Do you like the shape of your teeth? **Yes/No**

Are your teeth chipped? **Yes/No**

Can you see dark restorations on your teeth that bother you? **Yes/No**

Are there old crowns, bridges or fillings you do not like? **Yes/No**

Have you ever been concerned about an odor or bad taste in your mouth? Yes/No

Rate your smile on a scale of 1-10: _____

What would you like your smile to look like?

_____

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