Smile Evaluation

Name _____ Date _____

Email _____ Phone _____

Your smile is one of the first things people notice about you. To assist in your consultation, please answer the following questions.

What is your main reason for seeking a consultation regarding esthetic dentistry?

_____

_____

_____

Do you ever…

Yes No Avoid Smiling?
Yes No Cover your mouth with your hand when you smile?
Yes No Grind or clench your teeth?

Do you have…

Yes No Spaces between your teeth?
Yes No Missing teeth?
Yes No Old dental work that you are not satisfied with?
Yes No Chipped or worn down teeth?
Yes No Stained or discolored teeth?
Yes No Uneven teeth?
Yes No Uneven gums?
Yes No Teeth that are too long?
Yes No Teeth that are too short?
Yes No Dark metal fillings that are visible when you laugh or smile?
Yes No Clicking or sore jaw joint?
Yes No Soreness or stiffness of jaw muscles?

If you could wave a magic wand and change anything about your smile, what would you change?

_____

_____

_____

_____