Personalized Smile Evaluation

Name: _____
Date: _____

Please take a moment to look at your teeth and gums carefully, and then answer the following questions:

1. On a scale of 1 to 10 (10 being the best rating), how do you feel about your teeth and smile? _____
2. Are your teeth crooked or crowded, and is that a concern?

   _____
3. Do you have any space between your teeth that bother you?

   a. Yes b. No
4. Do you like the color of your teeth?

   a. Yes b. No

   Comment: _____
5. Do you like the shape of your teeth?

   a. Yes b. No
6. What would you like to change about the appearance of your teeth or smile?

   _____

   _____

   _____