



Personal Smile Evaluation

Name: _____ *Date:* _____

Do you like the appearance of your smile? Yes No If no, explain _____

Do you like the color of your teeth? Yes No If no, explain _____

Do you like the shape of your teeth? Yes No If no, explain _____

Are your teeth chipped? _____ Protruding _____ Hidden _____

Do you have spaces that you don't like? Yes No If yes, explain _____

Are your teeth all in alignment? Yes No If no, explain _____

Do you like the way your teeth come together? Yes No If no, explain _____

Do you have old fillings you don't like looking at? Yes No If no, explain _____

What would you like to change about your teeth? _____
