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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, how do you feel about your teeth and smile?_____

2. Are your teeth crooked or crowded and is that a concern?
Please comment. _____

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

4. Do you like the color of your teeth? Please comment.

5. Do you like the shape of your teeth? Please comment.

6. What would you like to change about the appearance of your smile?

7. Have you ever considered how you might feel with a brighter smile? Please comment.