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DENTAL ARTS PA

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Smile Evaluation

Name: ____

Date: _____________________

We would like to help you obtain the smile you have always wanted. Look in the mirror or at a photograph and please observe your teeth carefully. Our goal is to provide you with the best dental treatment possible and to answer your questions and discuss with you any areas of concern you may have. Please answer this questionnaire to help us better meet your dental needs.

Are you unhappy with your teeth and their appearance? ______________________________

Do you think you have active decay or gum disease?_______________________________

Are you unhappy with the spacing between your teeth?______________________________

Does food catch between your teeth?____

Are you unhappy with the color of your teeth?____________________________________

Are you unhappy with the shape of your teeth?___________________________________

Are you unhappy with the way your teeth fit together when you bite? _____________________

Are you unhappy with the way your jaw aligns? ___________________________________

Are your teeth:

Chipped?___________________

Protruding?__________________

Crowded?___________________

If you could change anything about the appearance of your smile, what would that be?

a. ____

b. ____

c. ____

d. ____