BENDER DENTAL GROUP

Smile Evaluation

Name_________________________________ Date____________________________

1. Do you like the way your teeth look? Yes ☐ No ☐
   Explain:____

2. Are you happy with the color of your teeth? Yes ☐ No ☐
   Explain:____

3. Would you like for your teeth to be whiter? Yes ☐ No ☐
   Explain:____

4. Would you like your teeth to be straighter? Yes ☐ No ☐
   Explain:____

5. Do you have spaces between your teeth that you would like closed? Yes ☐ No ☐
   If so, where?____

6. Would you like your teeth to be longer? Yes ☐ No ☐
   If so, Upper___ Lower_____ Both______?

7. Do you like the shape of your teeth? Yes ☐ No ☐
   Explain:____

8. Do you have missing teeth that you would like to replace? Yes ☐ No ☐
   Explain:____

9. Do you have old silver fillings that you would like to replace with tooth-colored fillings?
   Yes ☐ No ☐
   Explain:____

10. If you could change anything about your smile, what would you change?_________
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