Personalized Smile Evaluation

Patient_____ (to be filled out by patient)

Date_____

Please take a moment to look at your teeth and gums carefully and then answer the following questions. Your answers are personal and held in strict confidence.

1. On a scale of 1 to 10, how do you feel about your teeth and smile? (1-worst, 10-best) _____
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 you 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. _____

   _____

▼ Do not fill out below (in-office use only) ▼

Smile Enhancement Checklist

(in-office use only)

Patient_____

Date_____

Midline_____ Rotations_____ Diastemas_____

Labioversion, Linguoversion, X-bite_____Staining_____

Smile Line _____ Gingival Profile_____ Buccal Corridors_____

_____Photos ____Study Models ____Face-bow

Notes: _____

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