



## Smile Evaluation

**Please take a moment and answer the following questions carefully.**

**These answers will help us in addressing your specific needs more effectively. Our mission is to provide you with the smile that you have always wanted.**

1. What would you like to change the most in the appearance of your teeth?

- |                          |                              |                             |
|--------------------------|------------------------------|-----------------------------|
| Color of your teeth?     | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Shape of your teeth?     | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Size of your teeth?      | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Are your teeth straight? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Do you have gaps?        | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

2. Do you have problems with bad breath? Yes  No

3. Do you have problems with snoring? Yes  No

4. Are you interested in replacing your metal (Mercury) fillings with white (Composite) fillings? Yes  No

5. Do you suffer from any of the following orthodontic conditions:

- |            |                              |                             |
|------------|------------------------------|-----------------------------|
| Crowding   | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Open Bite  | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Under Bite | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Over Bite  | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

6. Do you grind your teeth at night or during the day? Yes  No

7. Do you need to protect your teeth during sports with a mouth guard?  
Yes  No

8. Please use the following space to address any additional concerns that you might have. Our dentists can successfully treat all of the above problems.

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