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GENERAL DENTISTRY

# YOUR PERSONAL SMILE EVALUATION

Name _____ Date _____

When I see a picture of myself:

_____ I wish my teeth were whiter

_____ I wish I had a wider or broader smile

My teeth are:

_____ Crowded _____ Crooked

_____ Uneven _____ Overlapped

_____ Sensitive to cold, hot or sweets _____ Rough-edged

My gums show:

_____ Too much _____ Not enough

_____ My top teeth do not show enough

_____ There is too much space between some of my teeth

_____ I am not completely pleased with my smile

_____ I sometimes hesitate to smile

_____ I am interested in options available for enhancing my smile