

Smile Evaluation

Name:

Date: / /

Do you like the way your teeth look? Yes / No

Explain:.....
.....
.....

Are you happy with the color of your teeth? Yes / No

Explain:.....
.....
.....

Would you like for your teeth to be whiter? Yes / No

Explain:.....
.....
.....

Would you like your teeth to be straighter? Yes / No

Explain:.....
.....
.....

Do you have spaces between your teeth that you would like closed? Yes / No

If so, where?
.....
.....

Would you like your teeth to be longer? Yes / No

If so, which ones? Upper / Lower / Both

Do you like the shape of your teeth? Yes / No

Explain:.....
.....
.....

Do you have missing teeth that you would like to replace? Yes / No

Explain:.....
.....
.....

Do you have old silver fillings that you would like to replace with tooth-colored fillings? Yes / No

Explain:.....
.....
.....

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

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