# *Do you have a great* SMILE

Smile Assessment for (Patient's Name): _____

| Yes | No | |
|---|---|---|
| ☐ | ☐ | Are you comfortable showing your teeth when you smile? |
| ☐ | ☐ | Are you happy with the appearance of your teeth? |
| ☐ | ☐ | Do you have unsightly crowns or fillings? |
| ☐ | ☐ | Do you feel your teeth are too long? |
| ☐ | ☐ | Do you feel your teeth are too short? |
| ☐ | ☐ | Do you like the color of your teeth? |
| ☐ | ☐ | Are you interested in improving the appearance of your teeth? |
| ☐ | ☐ | Are you interested in esthetic (cosmetic) dentistry? |

Please feel free to explain any answers…

_____

_____

_____

_____