Joseph J. Delmonico, D.D.S.

SMILE EVALUATION

Name:_____ Date:_____

1. Do you like the way your teeth look? YES NO

Explain:_____

2. Are you happy with the color of your teeth? YES NO

Explain:_____

3. Would you like your teeth to be whiter? YES NO

Explain:_____

4. Would you like your teeth to be straighter? YES NO

Explain:_____

5. Do you have spaces between you teeth that you would like closed? YES NO

Explain:_____

6. Would you like your teeth to be longer? YES NO

If so, upper, lower, or both? _____

7. Do you like the shape of your teeth? YES NO

Explain:_____

8. Do you have missing teeth that you would like to replace? YES NO

Explain:_____

9. Do you have old silver fillings that you would like to replace with tooth-colored fillings? YES NO

Explain:_____

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

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