SMILE!
EVALUATION

Dr. Ford would like to help you obtain the smile you have always wanted. Please take a few minutes to respond to the questions below; using a mirror or looking at a recent photograph would result in a more accurate observation.

NAME_____ **DATE**_____

1. Do you like your smile? _Yes _No
Please Explain
_____
_____

2. Do you like the color of your teeth? _Yes _No
Please Explain
_____
_____

3. Do you like the alignment of your teeth? _Yes _No
Please Explain
_____
_____

4. Do you like the spacing of your teeth? _Yes _No
Please Explain
_____
_____

5. Do you like the length of your teeth? _Yes _No
Please Explain
_____
_____

6. Do you like the shape of your teeth? _Yes _No
Please Explain
_____
_____

7. Do you have any missing teeth that you would like replaced? _Yes _No
Please Explain
_____
_____

8. Do you have any silver fillings that you would like replaced with tooth colored fillings? _Yes _No
Please Explain
_____
_____

If you could change/improve anything about your smile, what would that be? Please use the space below to capture any general comments or concerns.
_____
_____
_____

Thank you for taking time to fill out the SMILE! Evaluation. Our goal is to provide you with the best care to enhance your SMILE!