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Your Confidential Smile Analysis

Name_____**Date**_____

Do you like your smile? _____

Do you like the appearance of your teeth?_____

Do you like the color of your teeth?_____

Do you have spaces between your teeth that you do not like?_____

Do you like the size and shape of your teeth?_____

Are your teeth chipped?_____

Do you have fillings or dental work that you do not like looking at?_____

Do you have white spots that you would like to see disappear?_____

Do you have headaches or facial pain? Yes No

Have you ever had botox or dermal filler treatment? Yes No

What would you like to change about your smile?_____