

# 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?  
Please Explain

\_Yes

\_No

---

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

\_Yes

\_No

---

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

\_Yes

\_No

---

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

\_Yes

\_No

---

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

\_Yes

\_No

---

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

\_Yes

\_No

---

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

\_Yes

\_No

---

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

\_Yes

\_No

---

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!**