West Coast Dental Services, Inc.

Patient name: _____

Chart #: _____

Phone: _____ **Fax:** _____

SMILE EVALUATION

Obtain the Smile you've always wanted

Hold the mirror 12" 14" from your face, smile to show your teeth, take time to observe your teeth carefully, and answer the following questions.

Do you like the appearance of your teeth when you smile? ☐Yes ☐No

If not, Explain_____

Are your teeth all in alignment (straight)? ☐Yes ☐No

If not, Explain_____

Are any of your teeth Chipped, Protruding, Hidden? ☐Yes ☐No

Do you have spaces that you don't like? ☐Yes ☐No

If not, Explain_____

Do you like the color of your teeth? ☐Yes ☐No

If not, Explain_____

Do you like the way your teeth come together? ☐Yes ☐No

If not, Explain_____

What would you like to change the most about the appearance of your Teeth?