Patient Name_________________________________ ***Date*** ________________

Smile Evaluation

<u>Please rate each question on a scale of 1 to 5 with 5 being greatly satisfied</u>

1. How happy are you with the appearance of your teeth?

Color	1	2	3	4	5
Shape	1	2	3	4	5
Size	1	2	3	4	5
Alignment	1	2	3	4	5

2. Do you have any old fillings or other dental treatment you are not happy with?
YES NO

3. Do you have any missing teeth you would like to replace?
YES NO

4. Do you have any problems with jaw pain or tension headaches?
YES NO

5. Is there anything specific you would like to change about your smile? If so, please explain:

____

6. Do you have any other concerns you want Dr. Das to be aware of? If so, please explain:

____

We look forward to getting to know you and helping you achieve your dental goals. Please let us know how we can make your visits as comfortable as possible. We're here to help!