HOLT Family & Cosmetic DENTAL CARE

Holt Dental Care
Smile Evaluation

Patient Name:_____ **Date:**_____

We would like to help you obtain the smile you have always wanted. Please take a few minutes to complete this short Smile Evaluation. While using a mirror or looking at a photograph, please observe your teeth carefully.

1. **Are you pleased with the appearance of your teeth when you smile?**

_____

2. **Do you have any concerns about bad breath?**

_____

3. **Are there spaces between your teeth that you do not like?**

_____

4. **Are you pleased with the shape of your teeth?**

_____

5. **Are you pleased with the color of your teeth?**

_____

6. **Are your teeth:**
Chipped?_____ **Protrouding?**_____**Hidden?**_____ **Crowded?**_____

7. **Do you like the way your teeth fit together when you bite?**

_____

8. **Are there old fillings or dental treatment that you are not happy with?**

_____

9. **What would you change (if anything) about your smile?**

_____

10. **Would you like to see how your smile could look different?**

_____