Smile Evaluation


Do you like the appearance of your teeth/smile? _____


Do you like the color of your teeth? _____


Do you grind/clench your teeth? _____


Do you have any teeth that are:

_____Chipped _____ Broken_____ Worn down

_____ Out of alignment


Have you ever had:

_____ Periodontal (gum) treatment

_____ Orthodontic Care


Interested In:

_____ Clear aligners (Invisalign) _____ Whitening


Place a ___X___next to any of the following that are concerns regarding dental treatment to improve your smile.

_____Fear of Treatment _____ Financial Concerns

_____Not understanding Treatment

_____Other_____