



Smile Evaluation

F L E T C H E R
D E N T A L C A R E

Name _____ Date _____

Rate the appearance of your teeth and your smile (with 10 being the best):

☹ 1—2—3—4—5—6—7—8—9—10 ☺

Are your teeth straight? Yes No
If not, explain _____

Do you have spaces between your teeth that you don't like? Yes No
If yes, explain _____

Do you like the color of your teeth? Yes No
If not, explain _____

Do you like the shape of your teeth? Yes No
If not, explain _____

Do you like the way your teeth come together? Yes No
If not, explain _____

Are there any old fillings or dental work that you don't like looking at? Yes No
If yes, explain _____

Do you like the appearance of your gum? Yes No
If not, explain _____

What would you like to change the most about the appearance of your teeth? How would you like your teeth to look? _____

Is there anything else about your teeth you would like to address: Yes No
If yes, explain _____

We do Oral Conscious Sedation. Would you like to be sedated? Yes No

Thank you for letting us better help you.