



Smile Analysis

~best when performed in front of a mirror~

Check all that apply:

- I don't like the color of my teeth
- My teeth look worn down
- My teeth are chipped or cracked
- My teeth are crowded and not straight
- I feel like I have a "gummy" smile
- My teeth look too short
- My teeth look too long
- I have dark or silver fillings that I'd like replaced
- I have crowns with dark lines at the gum line
- I have a dark tooth/teeth from an injury
- I have tried over the counter whitening gel
- I like the results of my whitened teeth
- I use whitening toothpaste and/or mouthwash
- I am a smoker
- I drink ____ cups of coffee per day
- I drink ____ cups of tea per day

Please list any other questions or concerns you have that would assist us in understanding the goals you have for your teeth and smile:

Name _____ Date _____