McCreight Progressive Dentistry

the MPD way
progressing the art of dentistry™

SMILE EVALUATION

Client's Name_____Date_____

This is a simple questionnaire to help create the SMILE you have always wanted!

1. Do you like the appearance of your teeth? ( ) Yes ( ) No
   of your smile? ( ) Yes ( ) No

   If not, what would you like to change? _____

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2. Are your teeth straight? ( ) Yes ( ) No

   If not, what changes would you make? _____

   _____

3. Do you have spaces between your teeth that you are unhappy with? ( )Yes ( ) No
   Where? _____

4. Do you like the color of your teeth? ( ) Yes ( ) No

5. Are you happy with the shape of your teeth? ( ) Yes ( ) No

   If not, Why? _____

6. Are your teeth…….

   Chipped?_____Sticking Out?_____Crowded?_____

7. Do you have any old fillings or crowns that you are unhappy with? ( ) Yes ( ) No

   What would you change? _____

8. What would you like to change about the appearance on your teeth?

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