



## **SMILE EVALUATION**

*NAME* \_\_\_\_\_

*DATE* \_\_\_\_\_

Are you happy with the color of your teeth? \_\_\_\_\_

Do you like the appearance of your teeth, your smile? \_\_\_\_\_

Are your teeth straight? \_\_\_\_\_

Do you have spaces that you don't like? \_\_\_\_\_

Are your teeth chipped? \_\_\_\_\_ Protruding? \_\_\_\_\_ Hidden? \_\_\_\_\_

Do you like how your teeth come together when you bite? \_\_\_\_\_

Are there old fillings that you do not like? \_\_\_\_\_

What would you like to change the most in the appearance of your teeth? \_\_\_\_\_

\_\_\_\_\_

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