

Smile Check List

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you like your smile? Yes\_\_\_\_ No\_\_\_\_**

**Do you like the shape of your teeth? Yes\_\_\_\_ No\_\_\_\_**

**Do you like the color of your teeth? Yes\_\_\_\_ No\_\_\_\_**

**Do you smoke? Yes\_\_\_\_ No\_\_\_\_**

**Do you drink coffee or tea? Yes\_\_\_\_ No\_\_\_\_**

**Have you ever thought about whitening? Yes\_\_\_\_ NO\_\_\_\_**

**Do you have veneers or crowns? Yes\_\_\_\_ NO\_\_\_\_**

**Are your teeth crowded or spaced? Yes\_\_\_\_ NO\_\_\_\_**

**Would you be interested in straightening them? Yes\_\_\_\_ NO\_\_\_\_**

**What would you change about your smile? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Would you be interested in improving your overall smile? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**