

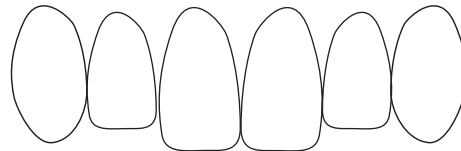


Smile Assessment

Dentist's Name: _____ Date: _____
 Fullname: _____ DOB: _____
 Address: _____
 Phone: _____ Email: _____

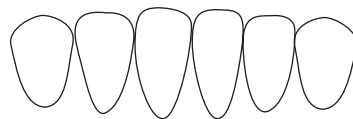
Six Upper Front Teeth

Upper Right Side



Upper Left Side

Lower Right Side



Lower Left Side

Six Upper Front Teeth

Please look at your teeth each day for the next week and make notation of any questions, concerns or ideas that you may have for your teeth. For example: colour, symmetry, shape, proportions, gum and lip line, smile line, angulations, discolouration, missing teeth.

What are your priorities as far as your teeth are concerned?

Description	Yes	No	Description	Yes	No
Comfort			Health		
Aesthetics			Function		
Longevity			Costs		
Predictability			Care Free		

Comments: _____

