Smile Evaluation Form

1) Do you like the appearance of your teeth and your smile? YES NO

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2) Do you like the color and shape of your teeth? YES NO

_____

3) Do you have any spaces or overlaps in your teeth that you don't like? YES NO

_____

4) What would you like to change the most about your teeth or smile? YES NO

_____

5) Do you have any old fillings, crowns or dental work that you do not like? YES NO

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