

SMILE ANALYSIS

PATIENTS NAME: _____

Please look into a mirror and evaluate the following:

HOW MANY TEETH ARE VISIBLE IN A FULL SMILE (circle correct number)

2 4 6 8 10 12

COLOR:

Are your teeth:

Too yellow?	<input type="radio"/> YES <input type="radio"/> NO	Too brown?	<input type="radio"/> YES <input type="radio"/> NO
Too dark?	<input type="radio"/> YES <input type="radio"/> NO	Too uneven in color?	<input type="radio"/> YES <input type="radio"/> NO
Too spotted?	<input type="radio"/> YES <input type="radio"/> NO	Too discolored?	<input type="radio"/> YES <input type="radio"/> NO
Too gray?	<input type="radio"/> YES <input type="radio"/> NO	Too light?	<input type="radio"/> YES <input type="radio"/> NO

DO YOUR TEETH HAVE UNATTRACTIVE FILLINGS OR RESTORATIONS?

YES NO

POSITION:

Are your teeth too crowded? YES NO
Do your teeth have spaces between them? YES NO
If your teeth have spaces (circle correct number) 1 2 3 4 5 6

SIZE:

Are your teeth:

Too long? YES NO
Too wide? YES NO
Too large? YES NO

Are your two upper center front teeth the same length or shorter than the two neighboring teeth?

Too short? YES NO
Too narrow? YES NO
Too small? YES NO

SHAPE:

Are your teeth unattractively shaped? YES NO
Too square? YES NO
Too irregular? YES NO

GUMS:

Do you show too much gum tissue (gummy smile)? YES NO
Are your gums red and/or swollen? YES NO
Does the shape of the gum surrounding the teeth appear unattractive? YES NO
Please list anything else about your smile you wish to discuss: _____

Signature: _____ Date: _____

