



Your Name _____

WHAT ASPECTS OF YOUR SMILE WOULD YOU LIKE TO IMPROVE?

___ CROWDING/CROOKED TEETH

___ MISSING TEETH

___ UGLY OLD CROWNS

___ JAW JOINT PAIN

___ SPACES

___ TOOTH SHAPE

___ DARK TEETH

___ TOOTH SIZE

___ SPEECH PROBLEMS

___ GUMMY SMILE

___ OVERBITE

___ UNDERBITE

___ FACIAL PROFILE

___ TEETH ARE DIFFERENT COLORS

___ OTHER _____

Is there anything else you would like the Dentist to know about your dental history?
