

Premier Dentistry

Smile Evaluation

1. Do you like the appearance of your teeth, your smile? Yes ___ No___

If not, explain_____

2. Are your teeth all in alignment (straight)? Yes___ No___

If not, explain_____

3. Do you have spaces that you don't like? Yes___No___

If yes, explain_____

4. Do you like the color of your teeth? Yes___No___

If not, explain_____

5. Do you like the shape of your teeth? Yes___No___

If not, explain_____

6. Are there any old fillings or dental work that you don't like the appearance of? Yes___ No___

If yes, explain_____

7. What would you like to change the most in the appearance of your teeth?

8. How would you like your teeth to look?_____

Personal Preferences

1. Would you like to watch tv during your dental visit? Yes___ No___

2. Please give us three examples of music you would like to listen to, if you

have a preference._____

3. Would you like to wear headphones during your visit? Yes___No___

4. Is there anything else we can do to make your visit more enjoyable? Yes___ No___

If yes, please explain_____
