Take Our

SMILE ASSESSMENT

AND SEE IF YOU MIGHT BE A CANDIDATE FOR AN ENHANCED SMILE

Name:_____ Date:_____

YES	NO	
○	○	Are you comfortable showing your teeth when you smile?
○	○	Are you happy with the appearance of your teeth?
○	○	Do you have unsightly crowns or fillings?
○	○	Are your teeth sensitive to hot or cold?
○	○	Do you feel your teeth are too long or too short?
○	○	Do you like the color of your teeth?
○	○	Are you interested in replacing missing teeth?
○	○	Do you feel like you always have bad breath?
○	○	Are your gums receding?

What is holding you back from your perfect smile?

- ○ Fear
- ○ Time
- ○ Cost
- ○ Other:_____

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