SMILE BY DESIGN NY

COSMETIC & IMPLANT DENTISTRY
Gary F. Turnier, DMD

Patient: ___________________

Date: ______________________

PERSONALIZED SMILE EVALUATION

(To be filled out by patient)

Please take a moment to look at your teeth and gums carefully and then answer the following questions. Your answers are personal and held in strict confidence.

1. On a scale of 1 to 10, how do you feel about your teeth and smile? (1 = worst, 10 = best) ____________
2. Are your teeth crooked or crowded and is that a concern?
   ____
3. Do you have any spaces between your teeth that bother you? ________________________
4. Do you like the color or your teeth? Please comment. ____________________________
5. Do you like the shape or your teeth? Please comment. ____________________________
6. What would you change about the appearance of your smile?
7. Have you considered how you might feel with a brighter smile? Please comment.

SMILE ENHANCEMENT CHECKLIST

(In-office use only.)

Midline: __________________ Rotations: ________________ Diastemas: ________________

Labioversion, Linguoversion, X-bite: __________________________ Staining: __________________

Smile Line: ________________ Gingival Profile: ___________ Buccal Corridors: __________

Photos: ____________ Study Models: _____________ Face-bow: __________

Notes: ____

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