Smile Survey

Name:______________________ Date:__________________

Check each of the following that applies to you:

- ☐ Bite feels off
- ☐ Teeth out of line
- ☐ Spacing or gaps between teeth
- ☐ Crowded teeth
- ☐ Dark lines around old crowns
- ☐ Visibly missing teeth
- ☐ Stained or discolored teeth
- ☐ Chipped or broken teeth
- ☐ Dark fillings that show
- ☐ Excessive gum tissue

Is there anything you would like to change about your smile?

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