

HYNDMAN AREA HEALTH CENTER
PO Box 706
144 Fifth Ave.
Hyndman, PA. 15545
(814) 842-3206
FAX: (814) 842-3746

SMILE EVALUATION

Patient's Name _____ **Date** _____

A simple questionnaire to help us create the SMILE you have always wanted!

1. Do you like the appearance of your teeth? Yes No
of your smile? Yes No

If not, what would you like to change? _____

2. Are your teeth straight? Yes No
If not, what changes would you make? _____

3. Do you have spaces between your teeth that you are unhappy with? Yes No

Where? _____

4. Do you like the color of your teeth? Yes No

5. Are you happy with the shape of your teeth? Yes No

If not, Why? _____

6. Are your teeth.....

Chipped? _____ Sticking Out? _____ Crowded? _____

7. Do you have any old fillings or crowns that you are unhappy with? Yes No

What would you change? _____

8. What would you like to change about the appearance of your teeth?
