

APPEARANCE OF YOUR TEETH FORM

Name: _____

Date: _____

If you could improve your smile in an easy, comfortable way, would you?

If you answer yes to any of the following questions, talk to Dr. Weigand about how you can improve your smile.

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| ▪ Do you like the <u>appearance</u> of your teeth? | Yes | No |
| ▪ Are your teeth in <u>alignment</u> (straight)? | Yes | No |
| ▪ Do you have <u>spaces</u> between your teeth? | Yes | No |
| ▪ Do you like the <u>color</u> of your teeth? | Yes | No |
| ▪ Do you wish your teeth were <u>whiter</u> ? | Yes | No |
| ▪ Are your teeth <u>protruding</u> ? | Yes | No |
| ▪ Are your teeth <u>hidden</u> ? | Yes | No |
| ▪ Are your teeth <u>wearing</u> on the biting surfaces? | Yes | No |
| ▪ Are there old crowns, bridges, or fillings you don't like looking at? | Yes | No |
| ▪ What would you like your smile to look like? | | |
