Nikki Christian & Wesley Christian
DENTISTRY

Smile Evaluation

Name_____Date_____

_____

1. **What are your chief dental concerns?_____**
2. **Do you dislike the color of your teeth? YES NO**
3. **Do you have spaces between your teeth that bother you? YES NO**
4. **Do you have chips or uneven edges in your teeth? YES NO**
5. **Do you feel your teeth are too long or too short? YES NO**
6. **Do you have dark fillings that show when you smile? YES NO**
7. **Do your gums show too much when you smile? YES NO**
8. **Are your teeth too crowded or crooked? YES NO**
9. **Do you have existing crowns or dental work you consider "ugly"? YES NO**
10. **Would you like to improve your existing smile? YES NO**
    _____
11. **Do you wish you had a "new smile"? YES NO**
12. **Do you have dental fears? YES NO If so, would you like to use Nitrous Oxide (laughing gas) for dental procedures? YES NO**
13. **I hereby authorize that any/all photographs taken by Drs. Wesley & Nikki Christian may be used for educational purposes. YES NO**
    Signature_____Date_____