Smile Evaluation

Please take a moment and answer the following questions carefully. These answers will help us in addressing your specific needs more effectively. Our mission is to provide you with the smile that you have always wanted.

1. What would you like to change the most in the appearance of your teeth?

Color of your teeth?	Yes ☐ No ☐
Shape of your teeth?	Yes ☐ No ☐
Size of your teeth?	Yes ☐ No ☐
Are your teeth straight?	Yes ☐ No ☐
Do you have gaps?	Yes ☐ No ☐

2. Do you have problems with bad breath? Yes ☐ No ☐

3. Do you have problems with snoring? Yes ☐ No ☐

4. Are you interested in replacing your metal (Mercury) fillings with white (Composite) fillings? Yes ☐ No ☐

5. Do you suffer from any of the following orthodontic conditions:

Crowding	Yes ☐ No ☐
Open Bite	Yes ☐ No ☐
Under Bite	Yes ☐ No ☐
Over Bite	Yes ☐ No ☐

6. Do you grind your teeth at night or during the day? Yes ☐ No ☐

7. Do you need to protect your teeth during sports with a mouth guard? Yes ☐ No ☐

8. Please use the following space to address any additional concerns that you might have. Our dentists can successfully treat all of the above problems.

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12932 Victory Boulevard North Hollywood, CA 91606 (818) 761-9000