RADIANT SMILES
OF ROCKY HILL
FAMILY • COSMETIC • IMPLANT DENTISTRY

Smile Evaluation Form

An ***optional*** form to complete if you would like an evaluation of your smile or to obtain the smile you always dreamed of…

1. Do you like the appearance of your teeth, your smile? If not, please explain: _____

   _____

2. Are your teeth all in alignment (straight)? If not, please explain: _____

   _____

3. Do you have spaces that you do not like? If so, please explain: _____

   _____

4. Do you like the color of your teeth? If not, please explain: _____

   _____

5. Do you like the shape of your teeth? If not, explain: _____

   _____

6. Do you like the way your teeth come together? If not, please explain: _____

   _____

7. Are there any old fillings or dental work that you do not like the appearance of? If yes, explain:

   _____

   _____

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

   _____

To provide you the proper attention, please use the space below to indicate any other problems, concerns or questions that you would like to have evaluated and discussed with you about your smile.

_____

_____

_____

Patient Name: _____ Date: _____

15 Rhodes Road, Rocky Hill, CT 06067 ● 860.563.4544

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