1. **Do you like the appearance of your teeth; your smile?**
   Yes ___ No ___
   If not, explain

2. **Are your teeth all in alignment (straight)?**
   Yes ___ No ___
   If not, explain

3. **Do you have spaces you don’t like?**
   Yes ___ No ___
   If not, explain

4. **Do you like the color of your teeth?**
   Yes ___ No ___
   If not, explain

5. **Do you like the shape of your teeth?**
   Yes ___ No ___
   If not, explain

6. **Are your teeth Chipped?_____ Protruding?_____ Hidden?_____**
   If not, explain

7. **Are your teeth wearing on the biting surfaces?**
   Yes ___ No ___
   If not, explain

8. **Are there old fillings or dental work you don’t like looking at?**
   Yes ___ No ___
   If not, explain

9. **What would you like to change the most in the appearance of your teeth?**
   If not, explain

10. **How would you like your teeth to look?**
    If not, explain