Smile Shack
Dr. Victoria E. Shack

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Let us know how we can help you with your smile!

NAME: _____ **DATE:** _____

1. Are any of your teeth yellow, stained or somewhat discolored?	☐ YES	☐ NO
a. Would you like your teeth to be whiter?	☐ YES	☐ NO
2. Do you have gaps or spaces between your teeth?	☐ YES	☐ NO
a. Would you like to have the gaps or spaces closed?	☐ YES	☐ NO
3. Are any of your teeth turned, crooked, or uneven?	☐ YES	☐ NO
4. Are you missing any teeth?	☐ YES	☐ NO
5. Do you see any pitting or defects on the surfaces of your teeth?	☐ YES	☐ NO
6. Are the edges of your teeth worn down, chipped, or uneven?	☐ YES	☐ NO
7. Do any of your teeth appear too smaill, short, large, or long?	☐ YES	☐ NO
8. Do you have any prior dental work that appears unnatural?	☐ YES	☐ NO
9. Do you have any crowns or bridges that appear dark at the edges?	☐ YES	☐ NO
10. Do you have any gray, black, or silver (murcury) fillings in your teeth?	☐ YES	☐ NO
11. DO you have a “gummy” smile (too much gum when smiling)?	☐ YES	☐ NO
12. Are your gums red, sore, puffy, bleeding or receded?	☐ YES	☐ NO
13. Does your teeth inihibit you from smiling or laughing?	☐ YES	☐ NO
14. When being photographed, do you smile with your lips closed?	☐ YES	☐ NO
15. Are you self-concious about your teeth?	☐ YES	☐ NO
16. Would you like to change anyting about the appeaance of your smile?	☐ YES	☐ NO

We can help you with all your needs for a beautiful smile! Please let us know what we can improve for you!

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