



## Smile Evaluation

Name: \_\_\_\_\_

Date: \_\_\_\_\_

*If you could wave a magic wand and change anything at all about your smile what would you change?*

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*We want you to know that we perform the latest techniques to correct most dental problems to give you the smile you've always wanted. Let us know how we can help.*

*I would like information about one or more of the following:*

*Check all that apply.*

Replacement of silver fillings with white fillings.

Teeth whitening.

Straightening teeth with and without braces.

Fixing spaces between teeth.

Change the shape of teeth.

Correcting chipped teeth.

The latest cosmetic dental techniques.

Help with bleeding gums.

Things to create fresher breath.

Treatment of sleep problems.

Treatment of chronic headache.

Learning about 0% dental financing.

**Thank you for taking time to supply this information. It will enable us to develop your personalized dental treatment plan.**