

 *Village Center*
DENTISTRY

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How Do You Rate Your Smile?

- | Yes | No | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | I would like to have a nicer smile |
| <input type="checkbox"/> | <input type="checkbox"/> | My teeth are stained or discolored |
| <input type="checkbox"/> | <input type="checkbox"/> | I have dark and unsightly fillings. |
| <input type="checkbox"/> | <input type="checkbox"/> | My teeth are crowded and crooked. |
| <input type="checkbox"/> | <input type="checkbox"/> | My gums are red, swollen, receding and/or bleeding. |
| <input type="checkbox"/> | <input type="checkbox"/> | I don't like the spaces between my teeth. |
| <input type="checkbox"/> | <input type="checkbox"/> | I have old unsightly crowns with black lines |
| <input type="checkbox"/> | <input type="checkbox"/> | My teeth are chipped and worn with rough edges. |
| <input type="checkbox"/> | <input type="checkbox"/> | I cover my mouth when I smile. |
| <input type="checkbox"/> | <input type="checkbox"/> | My teeth seem out of proportion. |

