Your "Smile" Questionnaire

Your Name_____**Date**_____

In order to evaluate your needs and expectations as accurately as possible, please help us by answering the following questions:

Do you feel that your teeth are (circle all responses):

Too small or short?	No	Yes
Too large or long?	No	Yes
Crooked or crowded?	No	Yes
Misshaped (uneven/pointed)?	No	Yes
Off Color?	No	Yes

Do you feel your front teeth "**stick out too much" ("Buck Teeth)**?
No Yes
Are there **spaces** between your teeth that you do not like?
No Yes
Is there **too much or too little gum tissue** showing when you smile?
No Yes
Has there been **previous orthodontic treatment (including braces or other appliances)**? No Yes
If so, when and by whom?
_____
_____

Are there other **dental issues not listed** above that you would like to discuss or have treated? No Yes (explain – other side if needed)

Is there a **time of the day/week** when you must have an appointment?

_____

Signature_____Relationship_____
Date_____