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

Have you had 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)

_____

_____

_____

Signature _____ Relationship _____

Date _____