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 ________________________  Date __________________________