CAPOGNA ORTHODONTICS
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# 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_____