Your "Smile" Questionaire

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 that apply):

Too small or too short? No Yes

Too large or too 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 that you would like to discuss or have treated?

No Yes (please explain)

Signature_____Relationship_____Date_____