Smile Questionnaire

New Patient Smile Survey

Patient Name: ________________________________ Date: ________________

In order to evaluate your teeth 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 in your 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?

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Are you aware that some appointments will require you to miss school/work?
No Yes

Signature ___________________ Relationship ______________ Date_________