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)
_____
_____
_____

Signature _____*Relationship*_____
*Date*_____