The Smile Questionnaire

Patient's name_____ Date _____

In order to accurately evaluate your needs and expectations please help us by answering the following questions.

Do you feel your teeth are:

- Too small or short? **Yes** **No**
- Too large or long? **Yes** **No**
- Crooked or crowded? **Yes** **No**
- Misshaped (uneven/pointed)? **Yes** **No**

Do you feel the front teeth are too far forward ("Buck Teeth")?

Yes **No**

Are there spaces between the teeth that you do not like?

Yes **No**

Do you see too much or too little gum tissue when smiling?

Yes **No**

Have you experienced previous orthodontic treatment (including braces, or other appliances)? **Yes** **No**

If so when? _____

Are there other issues not listed above that you would like to have changed?

Yes **No**

If yes please explain _____

Signature _____ Relationship to Patient _____

Date _____