Your "Smile" Questionnaire

Your Name: ____

In order to evaluate yours needs and expectations as accurately as possible, please help us by answering the following questions:

Do you feel that your teeth are (please circle as many responses as you like):

Too small or short?

Too large or long?

Crooked or crowded?

Misshaped (uneven/pointed)?

Off colour?

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 issues not listed above that you would like to discuss or have treated?

No Yes

Please give details:

Signature:

Date:

Please bring this completed form along to your consultation.