SMILE QUESTIONNAIRE

Patient Name: ____________________Date:_______________

Patients often request changes in their bite or face when visiting an orthodontist. 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 too small or short? NO YES

Are too large or long? NO YES

Are crooked or crowded? NO YES

Stick out too much? NO YES

Are centered within your face? NO YES

Have spaces/gaps that you do not like? NO YES

Concerning your face and smile...

Is there too much or too little gum showing when you smile? NO YES

Do you feel that your lower jaw/chin is too far back or forward? NO YES

Do you have any missing teeth or have impacted teeth? NO YES

Have you ever had braces before? NO YES

If so, when and by whom?

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Are there ANY issues concerning your teeth, face or smile not listed above that you would like to discuss or have treated?

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Signature ____________________Relationship to patient ______________________