THE ORTHODONTIST
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Your "Smile" Questionnaire

Patient's Name: ____Date:__________________________

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 that apply):

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 teeth "stick out too much" ("buck teeth")?

No Yes

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

No Yes

Does too much or too little gum tissue show 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 dental issues not listed above that you would like to discuss or have treated?

No Yes (Explain – use other side if needed)