YOUR "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 (circle all responses):

Too small or short?	NO	YES (upper/lower)
Too large or long?	NO	YES (upper/lower)
Crooked or crowded?	NO	YES (upper/lower)

Do you feel your front teeth **"stick out too much" (Buck Teeth?)** NO YES

Do you feel that your **upper teeth are centred** within your face? NO YES

Do you feel that **lower teeth are centred** within your face? NO YES

Are there **spaces/gaps** between your teeth that you do not like? NO YES

Has your dentist told you that you are **missing teeth or have impacted teeth**? 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? (please use space below).

_____

Do you feel that your lower jaw/chin (circle all responses):

Is too strong?	NO	YES (and want it corrected)
Is too weak?	NO	YES (and want it corrected)

Are there other **dental issues not listed** above that you would like to discuss or have treated? Please explain below (use other side if needed).

_____

Signature _____ Relationship to patient _____