beach braces

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YOUR 'SMILE QUESTIONNAIRE'

Your Name:______________________________ Date:_______________

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

1. **Do you feel that your teeth are (circle all appropriate responses):**
   - **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**
2. **Do you feel your front teeth stick out too much?**
   No Yes
3. **Are there spaces between your teeth that you do not like?**
   No Yes
4. **Is there too much or too little gum tissue showing when you smile?**
   No Yes
5. **Has there been previous orthodontic treatment (including braces or other appliances)? No Yes**
   If so, when and by whom?___________________________________
   ____
6. **Are there other dental issues not listed above that you would like to discuss or have treated? No Yes**
   If so, please explain:_______________________________________
   ____
   ____

Signature________________________ Relationship to patient:___________

Date:____________________