

New Smile Questionnaire

Use this questionnaire to help determine your feelings about your smile.

1. What bothers you the most about your smile?

2. Are there any spaces that you do not like? **Yes/No**

Is there a need for more space? **Yes/No**

Is crowding a problem? **Yes/No**

Explain: _____

3. (Look for esthetic problems) Ask yourself: "Does that (chip, stain, etc.) bother me?"
Yes/No

Explain: _____

4. Do you like the shape of your teeth? **Yes/No**

Explain: _____

5. Do you like the way your bottom teeth and top teeth fit together? **Yes/No**

Explain: _____

6. Do you have any discolored or old fillings that bother you or that you don't like seeing when you smile? **Yes/No**

7. Are your teeth as bright as you would like? **Yes/No**

Explain: _____

8. How would you like your smile to look?

9. Has anyone ever shown you what you'd look like if you changed your smile? **Yes/No**