Name _____

Date of Birth:_____ Today's Date_____

Please answer the following questions to aid our diagnosis and treatment of your dental appearance related concerns:

1. What is your best facial feature(s), e.g. eyes, nose, hair, etc.?_____
2. How would you describe your lips? Full, average, thin, etc. _____
3. Do you have spaces between your teeth?_____
4. Do these spaces bother you? _____
5. Do you have chips or uneven edges on teeth?_____
6. Does the color of your teeth bother you?_____
7. Does the shape of your teeth bother you? _____
8. Does the position of the teeth bother you? _____
9. Do you feel that your teeth are too crowded? _____
10. Are your teeth too short or too long?_____
11. Which arch bothers you? Upper_____ Lower _____ Both _____
12. How long has your smile been bothering you?_____
13. Have you ever had orthodontics treatment?_____
14. Please explain how you feel about your smile?_____

_____

_____

Signature_____ Date _____