

# Please tell us about your smile

Your name: \_\_\_\_\_

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 that apply):**

Too small or short?	No	Yes
Too large or long?	No	Yes
Crooked or crowded?	No	Yes
Misshaped (uneven/pointed)?	No	Yes
Discolored?	No	Yes

**Do you feel that your teeth stick out too much ("Buck teeth")?** No Yes

**Are there spaces between your teeth that you do not like?** No Yes

**Is there too much gum tissue showing when you smile?** No Yes

**Has there been previous orthodontic treatment?** 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) \_\_\_\_\_  
\_\_\_\_\_

**Signature** \_\_\_\_\_

**Date** \_\_\_\_\_