Morristown
COSMETIC DENTISTRY

Your Smile Questionnaire

This questionnaire is 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?

   Explain: _____

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

Patient Signature _____ **Date**_____