



Smile Survey

Your Name _____ Date _____

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

Do you have any of the following concerns regarding your teeth?

Silver fillings that show when you smile?	Yes _____ No _____
Missing teeth?	Yes _____ No _____
Crooked or crowded teeth?	Yes _____ No _____
Spaces or gaps?	Yes _____ No _____
Too small or short?	Yes _____ No _____
Too long or large?	Yes _____ No _____
Misshaped teeth?	Yes _____ No _____
Chipped teeth?	Yes _____ No _____
Discolored teeth?	Yes _____ No _____

Would you like to have a lighter whiter smile? Yes _____ No _____

Do you grind your teeth at night? Yes _____ No _____

Do you play a sport? If so, what? _____ Yes _____ No _____

Are there other dental issues not listed above that you would like to have discussed or treated? _____

Thank you for taking the time to answer this survey. We are here to help you have the smile you have always wanted.