Smile Questionnaire

Please complete the questionnaire and bring to your examination appointment.

Please circle the answer to the following questions. If No please briefly explain why in the space provided

How would you rate your smile out of 10? (10 being perfect)

1 2 3 4 5 6 7 8 9 10

Do you have gaps in your teeth that you are unhappy with? Y N

Is there any part of your smile you would like to change? Y N

Are you satisfied with the colour of your teeth? Y N

Would you like to know the shade of your teeth? Y N

Are you happy with the alignment of your teeth? Y N

Are you unhappy with the appearance of any fillings or other dental work? Y N

Are your teeth sensitive? Y N

How many times a day do you brush your teeth? 1 2 3

Do your gums bleed when you brush your teeth? Y N

Do you use an electric or a manual toothbrush? Y N

Do you use mouthwash everyday? Y N

Do you floss everyday? If yes with toothpick or an interdental brush? Y N

Do you grind, squeeze or clench your teeth together? Y N

Are you interested in Teeth Alignment and/or Teeth Whitening? Y N

Patient Name & Signature:

Date: