



With recent advancements in materials and techniques, many of our patients are inquiring about cosmetic dental procedures. In order to better serve you, please take a moment to let us know how you feel about the appearance of your smile.

Name _____ Date _____

	Yes or No	
Do you like the appearance of your teeth?	<input type="checkbox"/>	<input type="checkbox"/>
Are your teeth as straight as you would like them to be?	<input type="checkbox"/>	<input type="checkbox"/>
Are you happy with the length, width, and shape of your teeth?	<input type="checkbox"/>	<input type="checkbox"/>
Do you think you have a "gummy" smile?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any chipped teeth?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any missing teeth?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any spaces between your teeth?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any discoloration, stains, or spots on your teeth?	<input type="checkbox"/>	<input type="checkbox"/>
Would you like your teeth to be whiter?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any dental work that you are not satisfied with?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any silver fillings that you would like to change to white?	<input type="checkbox"/>	<input type="checkbox"/>

From the above questions which concerns you the most?

If you could change anything about the appearance of your teeth what would it be?
