



garlockORTHODONTICS

**SMILE QUESTIONNAIRE**

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Patients often request changes in their bite or face when visiting an orthodontist. 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 too small or short? NO YES
- Are too large or long? NO YES
- Are crooked or crowded? NO YES
- Stick out too much? NO YES
- Are centered within your face? NO YES
- Have spaces/gaps that you do not like? NO YES

**Concerning your face and smile...**

- Is there too much or too little gum showing when you smile? NO YES
- Do you feel that your lower jaw/chin is too far back or forward? NO YES
- Do you have any missing teeth or have impacted teeth? NO YES
- Have you ever had braces before? NO YES
- If so, when and by whom?

\_\_\_\_\_  
Are there ANY issues concerning your teeth, face or smile not listed above that you would like to discuss or have treated?  
\_\_\_\_\_  
\_\_\_\_\_

Signature \_\_\_\_\_ Relationship to patient \_\_\_\_\_