Encinitas
Pediatric Dentistry

Your "Smile" Questionnaire

Name:_____ Date: _____

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 (circle all responses):

Too small or short?	No	Yes
Too large or long?	No	Yes
Crooked or crowded?	No	Yes
Misshaped (uneven/pointed)?	No	Yes
Off Color?	No	Yes

Do you feel your front teeth stick out too much ("buck teeth")?
No Yes

Are there spaces between your teeth that you do not like?
No Yes

Has there been previous orthodontic treatment (including braces or other appliances)?
No Yes

If so, when and by whom?
_____

Is there a specific time of the day or week when you must be seen?
_____

Are there other dental issues not listed above that you would like to discuss or have treated?
No Yes (explain)

_____
_____
_____

Signature _____ Relationship _____