

Smile Information

Is there anything about your smile that you do not like? Yes/no

If yes please  
describe:

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Are you interested in knowing the options available for a more beautiful smile?

Yes/No

Do you like the appearance of your teeth? Yes/No

Are all of your teeth in alignment (straight)? Yes/No

Do you have any missing teeth? Yes/No

Are any of your teeth chipped? Yes/No

Is your bite comfortable when chewing, biting? Yes/No

Do you have frequent headaches? Yes/No

Do you have any old fillings/dental treatment that you are unhappy with? Yes/No

What would you like to change the most about the appearance of your teeth?

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Is there anything else that you would like us to know?

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