

Name:

Date:

DENTAL COSMETIC QUESTIONNAIRE

In order to evaluate your needs and expectations as accurately as possible, please help us by answering the following questions, circle any words that may apply, and provide us with any additional information.

How do you rate your smile on a scale of 1-10 with 10 being the best smile?

When I see a picture of myself, the first thing I notice about my smile is:

Do you like the color of your teeth? (dark, dull, stained, mismatched?)

Do you feel that your teeth are too small or too large?

Are your teeth crooked or out of line?

Are there spaces between your teeth you don't like?

Do you show a lot of gum tissue when you smile?

Are your gums irregularly shaped (higher or lower on some teeth)?

Are the biting edges of your teeth uneven, worn down, or chipped?

Do your teeth slant one way or another?

Are there any dental fillings or crowns that don't match your teeth?

Are any of your teeth missing?

Do you feel that you don't show enough teeth when you smile?

Is there anything else about your smile or teeth that you don't like, would like to change, or would like us to know about?

