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## How do you feel about your Smile?

Your smile plays a lot of important roles. It's an introduction, an invitation and a way to express how you feel - it says so much about you. A beautiful, confident smile spells success and can lead to many opportunities in both your personal and professional life.

To assess your personal feelings about your smile, fill in the following questionnaire. It will take just a few moments to answer the questions and provide a blueprint that will help us determine the type of treatments best suited to your unique situation.

	Yes	No
1. Do you feel pain in any of your teeth?.....	<input type="checkbox"/>	<input type="checkbox"/>
<i>If yes, where:</i> _____		
2. Are any of your teeth sensitive to: (circle) cold hot sweets biting .....	<input type="checkbox"/>	<input type="checkbox"/>
3. Do you have any broken fillings? .....	<input type="checkbox"/>	<input type="checkbox"/>
4. Were you ever told you have periodontal disease? .....	<input type="checkbox"/>	<input type="checkbox"/>
5. Are your gums puffy, red or swollen-looking? Do they bleed easily? .....	<input type="checkbox"/>	<input type="checkbox"/>
<i>If yes, please explain:</i> _____		
6. Are you pleased with the general appearance of your teeth and smile? .....	<input type="checkbox"/>	<input type="checkbox"/>
<i>If no, please explain:</i> _____		
7. Have you ever had orthodontic treatment? .....	<input type="checkbox"/>	<input type="checkbox"/>
8. Are there spaces between your front teeth that you dislike? .....	<input type="checkbox"/>	<input type="checkbox"/>
9. Are you satisfied with the color of your teeth? .....	<input type="checkbox"/>	<input type="checkbox"/>
<i>If no, please explain:</i> _____		
10. Do you have old fillings or dental work that you think would look much better white?.....	<input type="checkbox"/>	<input type="checkbox"/>
11. Are you satisfied with the shape of your teeth? .....	<input type="checkbox"/>	<input type="checkbox"/>
<i>If no, please explain:</i> _____		
12. Are any of your teeth Chipped? Hidden? Protruding? .....	<input type="checkbox"/>	<input type="checkbox"/>
<i>If yes, please describe:</i> _____		
13. Are you satisfied with the way your teeth come together (bite)?.....	<input type="checkbox"/>	<input type="checkbox"/>
<i>If no, please explain:</i> _____		
14. Do you have any jagged teeth or teeth that you think are too long or too short?.....	<input type="checkbox"/>	<input type="checkbox"/>
15. What would you like to change about the appearance of your teeth? .....		
16. Do you have missing teeth that make chewing difficult?.....	<input type="checkbox"/>	<input type="checkbox"/>
17. Have you ever experienced any of the following problems from your jaws?		
Clenching or grinding of your teeth .....	<input type="checkbox"/>	<input type="checkbox"/>
Clicking Noise .....	<input type="checkbox"/>	<input type="checkbox"/>
Pain (joint, ear, side of face).....	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty in opening or closing.....	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty in chewing.....	<input type="checkbox"/>	<input type="checkbox"/>
Do you experience frequent headaches .....	<input type="checkbox"/>	<input type="checkbox"/>
Ear Congestion/Blocked feeling in ears .....	<input type="checkbox"/>	<input type="checkbox"/>

We'd like to review your responses with you and together determine the best treatment options to create the beautiful and confident smile you envision and deserve.