OWENS-BAKER
ORTHODONTICS

Your "Smile" Questionnaire

Patient Name:_____ Date:_____

To evaluate your needs and expectations as accurately as possible, please help us by answering the following questions:

Who is your family/general dentist?_____City/State_____

Do you schedule regular dental cleanings?.....YES NO
How often?_____ Date of last cleaning?_____

Do you feel that your teeth are (circle all that apply):

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

Does too much or too little gum tissue show when you smile?
No Yes (too little……too much)

Have you had previous orthodontic treatment (including braces or other appliances)?
No Yes
If so, when and by whom?_____

What are your chief concerns that you want orthodontics to address? Please indicate your goals and expectations of orthodontic treatment. (explain in detail, use other side if needed)

_____

_____

_____

_____

Signature _____ Relationship to patient: _____