

NAME _____

DATE _____

SMILE EVALUATION

We would like to help you obtain the best smile and bite possible. Please take a few minutes to complete this short questionnaire. Circle the appropriate answer next to each question. You may wish to use a mirror or look at a recent photograph in order to more closely examine your teeth and jaws.

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|--|-----|----|
| 1) Do you think your upper teeth are crooked? | YES | NO |
| 2) Do you think your lower teeth are crooked? | YES | NO |
| 3) Do you think your teeth protrude? | YES | NO |
| 4) Do you think your lips protrude too much? | YES | NO |
| 5) Do you think your lips are too recessive (too far back)? | YES | NO |
| 6) Do you think your bite is too deep in the front? | YES | NO |
| 7) Do you think your gums show too much when you smile? | YES | NO |
| 8) Would you like to change anything about the appearance of your smile?
If yes, please explain: _____ | YES | NO |
| 9) Is there anything about the shape or alignment of your jaws that you are not happy with?
If yes, Please explain: _____ | YES | NO |
| 10) Is there anything about your lips that you don't like?
If yes, please explain: _____ | YES | NO |
| 11) Do your lower teeth hit your gums behind your upper front teeth? | YES | NO |
| 12) Do you like the way your teeth fit together when you bite? | YES | NO |
| 13) Do your lips come together without strain when they are relaxed? | YES | NO |
| 14) Do you have any other concerns or comments that might help us in the evaluation of your smile? | YES | NO |