Smile Questionnaire

Today's Date: _____

Patient Name: _____

Date of Birth: _____

Reason for today's visit: _____

1. How important do you consider your oral health?
   Not important – somewhat important – very important

2. Which of the following oral health conditions have you experienced since your last dental exam? Please check all that apply.

   - ❏ Tooth ache
   - ❏ Loose, chipped, cracked or broken fillings
   - ❏ Grinding teeth
   - ❏ Clicking or popping jaw
   - ❏ Clenching jaw
   - ❏ Headaches
   - ❏ Snoring or sleep apnea
   - ❏ Sensitivity to hot, cold, or sweet foods
   - ❏ Red, puffy, or tender gums
   - ❏ Teeth have moved

3. On a scale from 1-10, how confident are you in your smile? Please circle your answer.

   1 2 3 4 5 6 7 8 9 10

4. If you could change your smile, would you:

   - ❏ Make your teeth whiter?
   - ❏ Close gaps between your teeth?
   - ❏ Make your teeth straighter?
   - ❏ Fix chipped or cracked teeth?
   - ❏ Replace missing teeth?
   - ❏ Other

5. Have you had your teeth straightened in the past? (Braces, clear aligners, or other appliances)

   - ❏ Yes (date: MM/DD/YY to MM/DD/YY)
   - ❏ No

6. When deciding to start dental treatment, rank these factors from most important to least important.

   - ❏ Comfort
   - ❏ Length of treatment
   - ❏ Price
   - ❏ Insurance coverage
   - ❏ Appearance/Aesthetics
   - ❏ Frequency of check-in appointments
   - ❏ Other (please specify):

7. When would you like to share your new smile with the world?

   - ❏ As soon as possible
   - ❏ Wedding (date: MM/DD/YY)
   - ❏ Birthday
   - ❏ Vacation
   - ❏ Reunion
   - ❏ Other

8. Is there anything else you'd like us to know?