First impression ORTHODONTICS
6479 Old Beulah Street | Alexandria, VA 22315 | P. 703.822.0010 / F. 703.822.0020
firstimpressionorthodontics.com

SMILE QUESTIONNAIRE

Patient Name:

Patients often request changes in their bite or face when visiting an orthodontist. In order to evaluate your needs and expectations as accurately as possible, please help us by answering the following questions:

Do you feel that your teeth. . .

Are too small or short?	NO	YES
Are too large or long?	NO	YES
Are crooked or crowded?	NO	YES
Stick out too much?	NO	YES
Are centered within your face?	NO	YES
Have spaces/gaps that you do not like?	NO	YES

Concerning your face and smile...

Is there too much or too little gum showing when you smile?	NO	YES
Do you feel that your lower jaw/chin is too far back or forward?	NO	YES
Do you have any missing teeth or have impacted teeth?	NO	YES
Have you ever had braces before?	NO	YES

If so, when and by whom?

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Are there ANY issues concerning your teeth, face or smile not listed above that you would like to discuss or have treated?

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combining the art&science of smiles!