Patient Survey

1) **Do you like the appearance of your teeth (your smile)?** ☐ Yes ☐ No

If not please explain: _____

_____

2) **Are your teeth all in alignment (straight)?** ☐ Yes ☐ No

If not please explain: _____

_____

3) **Do you have spaces that you don't like?** ☐ Yes ☐ No

If yes please explain: _____

_____

4) **Do you like the color of your teeth?** ☐ Yes ☐ No

If not please explain: _____

_____

5) **Do you like the shape of your teeth?** ☐ Yes ☐ No

If not please explain: _____

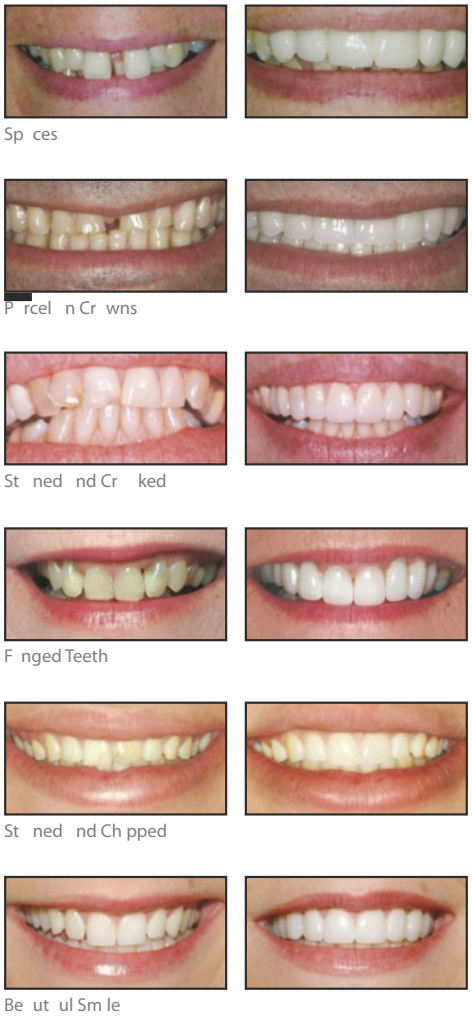
_____

6) **Are your teeth: chipped?** _____ **protruding?** _____ **hidden?** _____

7) **Are your teeth wearing on the biting surfaces?** ☐ Yes ☐ No

If yes please explain: _____

_____



8) **Are there old fillings or dental works you don't like?** ☐ Yes ☐ No

If yes please explain _____

_____

9) **What would you like to change the in the appearance of your teeth?**

_____

10) **How would you like your teeth to look?**

_____

_____