CENTER FOR DENTISTRY – FACULTY DENTAL OFFICE
SMILE ANALYSIS QUESTIONNAIRE

Name:_____ Date:_____

Your smile affects your self-image and can greatly influence the quality of your interactions with others. Many people hold back from laughing or smiling because they are uncomfortable with their smile. The following questions are designed to honestly appraise your smile and will give your doctor a chance to discuss any questions or concerns you may have about changing your aesthetic appearance so you can have the **Smile You Always Wanted!**

1. Are any of your teeth yellow, stained, or somewhat discolored?..... ☐Yes ☐No
2. Would you like your teeth to be whiter?..... ☐Yes ☐No
3. Do you have any gaps or spaces between your teeth?..... ☐ Yes ☐No
4. Are any of your teeth turned, crooked, or uneven?..... ☐Yes ☐No
5. Are you missing any teeth?..... ☐Yes ☐No
6. Do you see any pitting or defects on the surfaces of your teeth?..... ☐Yes ☐ No
7. Are the edges of any teeth worn down, chipped, or uneven?..... ☐Yes ☐No
8. Do any of your teeth appear too small, short, large, or long?..... ☐Yes ☐No
9. Do you have any prior dental work that appears unnatural?..... ☐Yes ☐ No
10. Do you have any crowns or bridges that appear dark at the edge of your gums?..... ☐Yes ☐ No
11. Do you have any gray, black, or silver (mercury) fillings in your teeth?..... ☐ Yes ☐No
12. Do you have a "gummy" smile (too much of your gums show when smiling)?..... ☐ Yes ☐No
13. Are your gums red, sore, puffy, bleeding, or receded?..... ☐ Yes ☐No
14. Does the appearance of your smile inhibit you from laughing or smiling?..... ☐ Yes ☐No
15. When being photographed, do you smile with your lips closed instead of flashing a full smile?.. ☐Yes ☐No
16. Are you self-conscious about your teeth or smile?..... ☐Yes ☐No
17. Would you like to change anything about the appearance of your teeth or smile?..... ☐Yes ☐No
    If yes, please explain:
    _____