

Your smile plays a lot of important roles. It's an introduction, an invitation and a way to express how you feel – it says so much about you. A beautiful, confident smile spells success and can lead to many opportunities in both your personal and professional life.

Nine out of ten people feel an attractive smile is an important asset. Yet, the majority of Americans are unhappy with some aspect of their smile. Modern cosmetic dentistry offers many options, and dental professionals are your best resource for information about cosmetic alternatives to improve the appearance of your smile.

To assess your personal feelings about your smile, fill in the following questionnaire. It will take just a few moments to answer the questions and provide a blueprint that will help us determine the type of treatments best suited to your unique situation.

- | | | Yes | No |
|---|--------------------------|-----|--------------------------|
| 1. Are you pleased with the general appearance of your teeth and smile? | <input type="checkbox"/> | | <input type="checkbox"/> |
| If no, please explain: _____ | | | |
| 2. Are your teeth straight? | <input type="checkbox"/> | | <input type="checkbox"/> |
| If no, please explain: _____ | | | |
| 3. Are there spaces between your front teeth that you dislike? | <input type="checkbox"/> | | <input type="checkbox"/> |
| 4. Are you satisfied with the color of your teeth? | <input type="checkbox"/> | | <input type="checkbox"/> |
| If no, please explain: _____ | | | |
| 5. Are you satisfied with the shape of your teeth? | <input type="checkbox"/> | | <input type="checkbox"/> |
| If no, please explain: _____ | | | |
| 6. Are any of your teeth chipped? Hidden? Protruding? | <input type="checkbox"/> | | <input type="checkbox"/> |
| If no, please explain: _____ | | | |
| 7. Are you satisfied with the way your teeth come together (bite)? | <input type="checkbox"/> | | <input type="checkbox"/> |
| If no, please explain: _____ | | | |
| 8. Are your gums puffy, red or swollen-looking? Do they bleed easily? | <input type="checkbox"/> | | <input type="checkbox"/> |
| If no, please explain: _____ | | | |
| 9. Do you have old fillings or dental work that you think would look much better white? | <input type="checkbox"/> | | <input type="checkbox"/> |
| 10. Do you have any jagged teeth or teeth that you think are too long or too short? | <input type="checkbox"/> | | <input type="checkbox"/> |
| 11. Do you have missing teeth that make chewing difficult? | <input type="checkbox"/> | | <input type="checkbox"/> |
| 12. Do you frequently bite the inside of your cheek while chewing food? | <input type="checkbox"/> | | <input type="checkbox"/> |
| 13. Have you ever experienced any of the following problems from your jaws? | <input type="checkbox"/> | | <input type="checkbox"/> |
| Clicking noise | <input type="checkbox"/> | | <input type="checkbox"/> |
| Pain (joint, ear, side of face). | <input type="checkbox"/> | | <input type="checkbox"/> |
| Difficulty in opening or closing | <input type="checkbox"/> | | <input type="checkbox"/> |
| Difficulty in chewing. | <input type="checkbox"/> | | <input type="checkbox"/> |
| Do you experience frequent headaches. | <input type="checkbox"/> | | <input type="checkbox"/> |
| 14. What would you like to change about the appearance of your teeth? _____ | | | |
| 15. How would you like your teeth to look? _____ | | | |

Please return your evaluation to us. We'd like to review your responses with you and together determine the best treatment options to create the beautiful and confident smile you envision and deserve.