

# Smile Survey



## About you

Title: Mr / Mrs / Miss / Ms / Other \_\_\_\_\_ Full Name \_\_\_\_\_

Home Tel. \_\_\_\_\_ Mobile \_\_\_\_\_

Work Tel. \_\_\_\_\_ Email \_\_\_\_\_

Preferred method of contact  Home Tel.  Mobile  Work Tel.  Email

## Questions

Yes No

1. Are any of your teeth stained or discoloured?  Yes  No
2. Are any of your teeth out of line?  Yes  No
3. Are any of your teeth damaged, misshapen or unsightly?  Yes  No
4. Are any of your teeth visibly missing?  Yes  No
5. Do you have any dark fillings?  Yes  No
6. Do you have any stained or discoloured fillings?  Yes  No
7. Do you have any crowns with visible edges?  Yes  No
8. Would you like whiter and brighter teeth?  Yes  No
9. Are your gums pink and healthy?  Yes  No
10. Do your gums bleed when brushing, flossing?  Yes  No
11. On a scale of 1-10 (10 being best), how would you rate your smile? \_\_\_\_\_
12. What would you change to your smile to make it a 10? \_\_\_\_\_
13. Are you interested in wrinkle correction treatment or softening facial lines?  Yes  No
14. Are you interested in lip enhancement treatment?  Yes  No
15. Would you like fresher breath?  Yes  No
16. Is there anything else regarding your smile and oral health that we can help you with? \_\_\_\_\_  
\_\_\_\_\_
17. Is finance an obstacle to having the healthy mouth and smile you would like? \_\_\_\_\_  
\_\_\_\_\_

Date \_\_\_\_\_

Signed \_\_\_\_\_