Smilesketch Boston

COSMETIC DENISTRY QUESTIONAIRE

Name_____ Date_____

COSMETIC DENTISTRY QUESTIONNAIRE

	Circle One
1) Do you want your teeth to be whiter?	Yes No
2) Do you want your gums to look better?	Yes No
3) Do you want to show more or fewer teeth when you smile?	Yes No
4) Do you think you show too much or too little gum when you smile?	Yes No
5) Do you want to have longer or shorter teeth?	Yes No
6) Would you prefer wider or narrower teeth?	Yes No
7) Do you wish your teeth were shaped or positioned differently?	Yes No
8) Does your self-confidence lessen when you smile?	Yes No
9) Do you ever try to cover your smile?	Yes No
10)When you look in the mirror do you see minor defects in your gums or in any teeth?	Yes No

TMD SCREENING QUESTIONNAIRE

1) Do you suffer from frequent headaches? (more than once a week)	Yes No
2) Do you ever have pain, discomfort or other sensations, such as ringing, roaring, stuffiness, etc around the ears, temples, neck or cheek?	Yes No
3) Does it ever hurt to chew?	Yes No
4) Does it ever hurt to open wide, take a big bite or yawn?	Yes No
5) Does your jaw ever make popping,cracking or grating noises?	Yes No
6) Does your jaw ever lock?	Yes No