Dr. Todd K. Rowe, Orthodontist, P.C.

Leominster, MA 01453

(978) 537-6100

Your Smile Questionnaire

Patient's Name: _____ Date: _____

In order to evaluate your needs and expectations as accurately as possible, please help us by answering the following questions:

Do you feel that your teeth are (circle all responses):

Too small or short?	No	Yes
Too large or long?	No	Yes
Crooked or crowded?	No	Yes
Off color?	No	Yes
Misshaped (uneven/pointed)?	No	Yes

Do you feel that your front teeth stick out too much (buck teeth)? No Yes

Are there spaces between your teeth that you do not like? No Yes

Is there too much or too little gum tissue showing when you smile? No Yes

Have you had previous orthodontic treatment (including braces or other appliances)? No Yes
If so, when and by whom? _____

Are there other dental issues not listed above that you would like to discuss or have treated?
No Yes (please explain)

_____

Signature: _____ Date: _____

Relationship: _____