Cosmetic Information

Is there anything about your smile that you do not like?
_____

Are you happy with the appearance (color, size, shape) of your teeth?
_____

Are your teeth crowded or crooked?_____

Are you missing any teeth? _____

Are any teeth chipped? _____

Is your bite comfortable when chewing and/or biting?_____

Does food get trapped between your teeth when you eat?_____

Do you have frequent headaches, neck pain and/or shoulder aches?
_____

Do you have any old fillings or dental treatment that you are unhappy with?
_____

What would you like to change the most about the appearance of your teeth?
_____

Are you interested in the options available for a more beautiful smile?
_____

Have you ever whitened your teeth? _____

Is there anything else you would like us to know? _____
_____

Please check if you have experienced any of these problems in the past or present?

□ Orthodontic treatment	□ Grinding/Clenching	□ Difficulty Opening / Closing Jaw
□ Periodontal treatment	□ Clicking/Popping	□ Sensitivity to Biting / Chewing
□ Bleeding Gums	□ Headaches	□ Dry Mouth
□ Bad Breath	□ Jaw Pain / Neck Pain	□ Sensitivity to Hot or Cold