Patient Survey

Patient Name: ______________________ **Date:** __________

Review and answer the questions below so we can help you achieve a healthy, straight, and glowing smile; ***the one you've always wanted.***

Yes	No	Survey Questions
☐	☐	Do you love the appearance of your smile?
☐	☐	Do you love the appearance of your teeth?
☐	☐	Do you love the color of your teeth?
☐	☐	Do you love the size of your teeth?
☐	☐	Do you have any tooth sensitivity?
☐	☐	Would you like to esthetically enhance any of your previous dental work?
☐	☐	Do you have spaces between your teeth or crowding you would like to modify?
☐	☐	Have you ever thought about straightening your teeth?

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