Dental Practice on the Hill
Healthy teeth. Happy smile.

SMILE QUESTIONNAIRE

Please complete and bring to your examination appointment

Name: ____________________________

Date of birth: _____________

Please circle the answer to the following questions:

How would you rate your smile out of 10? (10 being perfect)	1 2 3 4 5 6 7 8 9 10		
Is there any part of your smile you would like to change?	Y	N	
How many times a day do you brush your teeth?	1	2	3
Do you use an electric toothbrush?	Y	N	
Do you floss or use any other interdental cleaning aids?	Y	N	
Do your gums bleed when you brush or floss?	Y	N	
Are your teeth sensitive?	Y	N	
Are you unhappy with the appearance of any fillings or other dental work?	Y	N	
Are you satisfied with the colour of your teeth?	Y	N	
Do you have any white or brown marks on your teeth that concern you?	Y	N	
Do you clench or grind your teeth?	Y	N	
Do you have any gaps in your teeth that you are unhappy with?	Y	N	
Are you happy with the alignment of your teeth?	Y	N	
Are you concerned about facial lines or wrinkles?	Y	N	

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