MARKET WEIGHTON
DENTAL PRACTICE

SMILE QUESTIONNAIRE

Full 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**

Would you like your teeth to be whiter? **Y / N**

Do you have any gaps between your teeth that you are unhappy with? **Y / N**

Are you happy with the alignment of your teeth? **Y / N**

Any discoloured or silver fillings you don't like the appearance of? **Y / N**

Do you have any missing teeth you would like replacing? **Y / N**

Please let us know if there are any reasons why you are unhappy with your smile:

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