CONTEMPORARY DENTAL ARTS

Cosmetic Questionnaire

Are you experiencing any pain today?

____

Do you have a specific concern?

____

Are you happy with your smile? Yes ____ No____

If there was one thing you could change about your smile, what would it be?

____

____

Are your front teeth white enough?
Yes ___ No ___

Do you like the way they are shaped?
Yes ___ No ___

Are they as straight as you would like them to be?
Yes ___ No ___

Are you satisfied with your overall appearance?
Yes ___ No ___

Do you have sensitivity to hot or cold when you chew?
Yes ___ No ___

Do you have difficulty when chewing?
Yes ___ No ___

Are you missing any teeth?
Yes ___ No ___

Does food get trapped and annoy you?
Yes ___ No ___

Do your gums bleed?
Yes ___ No ___

Do you experience sensitivity?
Yes ___ No ___

Do you have issues with your breath?
Yes ___ No ___

Do you have removable appliances in your mouth? If so, are they comfortable? Yes___ No ___

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Do you have any questions or concerns that were not discussed on this form?

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