Dentistry at its finest
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Dentistry At Its Finest

Patient Name : _____

SMILE MAKEOVER QUESTIONNAIRE

1. Are you embarrassed and self-conscious by your smile? ☐ Yes ☐ No
2. Is this a new problem that occurred the last few years or a lifelong problem? ☐ Recent ☐ Lifelong
3. Do you cover your mouth with your hand when you go to laugh? ☐ Yes ☐ No
4. Is it one tooth, many of your teeth, or all your teeth that bother you? ☐ One ☐ Multiple ☐ All
5. Is it your upper front teeth, lower front teeth or both that bother you? ☐ Upper ☐ Lower ☐ Both
6. Do you think your smile negatively affects the way people view you? ☐ Yes ☐ No
7. Do you think your smile is negatively affecting your job or relationship possibilities? ☐ Yes ☐ No
8. How much bigger problem are your teeth, in your life? ☐ Huge ☐ Moderate ☐ Slight
9. Do you have prior dental work that looks unnatural or has dark lines along the gum line? ☐ Yes ☐ No
10. What problems about your smile would you like to correct?
    - ☐ Eliminate Spaces between teeth
    - ☐ Eliminate spaces at gum line
    - ☐ Teeth overlapped/crowded
    - ☐ Gum line uneven
    - ☐ Teeth worn down
    - ☐ Edges of teeth chipped
    - ☐ Yellow or discolored teeth
    - ☐ Size of teeth not pleasing: ☐ Too wide ☐ Too narrow ☐ Too long ☐ Too short
11. Do you have missing teeth that affects your smile? ☐ Yes ☐ No
12. How would you rate your smile? ☐ Horrible ☐ Not Spectacular ☐ Just Ok ☐ Pretty Good ☐ Close To Perfect
13. Do you think your smile can be fixed or do you think your teeth are hopeless? ☐ Treatable Problems ☐ Hopeless Problems
14. Is there anything else you would like Dr. Matarazzo to know about you or your smile?

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Signature of Patient: _____ Date: MM / DD / YYYY