C2 Dentistry
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Cosmetic Questionnaire

Name_____ **Date**_____

With recent advancements in materials and techniques, many of our patients are inquiring about cosmetic dental procedures. In order to better serve you, please take a moment to let us know how you feel about the appearance of your smile.

	Yes	No
Do You like the appearance of your teeth?	☐	☐
Are your teeth as straight as you would like them to be?	☐	☐
Are you happy with the length, width, and shape of your teeth?	☐	☐
Do you think you have a "gummy smile"?	☐	☐
Do you have any chipped teeth?	☐	☐
Do you have any spaces between your teeth?	☐	☐
Do you have any missing teeth?	☐	☐
Do you have any discolorations, stains or spots on your teeth?	☐	☐
Would you like for your teeth to be whiter?	☐	☐
Do you have any dental work that you do not like?	☐	☐
Do you have any silver fillings that you would like changed to white?	☐	☐
From the above questions, which concerns you the most?	☐	☐

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If you could change anything about the appearance of your teeth, what would it be?

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