David M. Bunkall, D.D.S., M.S., P.A.
o r t h o d o n t i c s

Your "Smile Questionnaire"

Patient's Name: ______________________________

Date: ______________________________

To evaluate your needs and expectations as accurately as possible, please help us by answering the following questions:

Do you feel that your teeth are:

Too small or short?	Yes	No
Too large or long?	Yes	No
Crooked or crowded?	Yes	No
Misshaped (uneven/worn)?	Yes	No
Out of place?	Yes	No

Do you feel that your front teeth "stick out too much"?

Yes No

Are there spaces between your teeth that you do not like?

Yes No

Does too much gum tissue show when you smile?

Yes No

Have you ever had previous orthodontic treatment?

Yes No

Are there other issues about your smile that you would like to discuss or have treated?

Yes No

If yes, describe: ______________________________

______________________________ Signature

______________________________ Relationship to Patient

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"Questionario de su Sonrisa"

Nombre de Paciente: ______________________________
Fecha: ______________________________

Para evaluar sus necesidades y expectativas por favor ayudenos contestando las sigientes preguntas:

Cree que sus dientes son:

Demasiado pequeños o cortos?	Si	No
Demasiado grandes o largos?	Si	No
Torsidos o empalmados?	Si	No
Deformados (desigual/gastados)?	Si	No
Fuera de lugar?	Si	No

Cree usted que sus dientes sobresalgan demasiado"?

Si No

Tiene espacios entre los dientes que no le gusta?

Si No

Muestra demasiada encia al sonreir?

Si No

A tenido tratamiento ortodontico aterior?

Si No

Ahi otros temas sobre su sonrisa que le gustaria discutir?

Si No

Describa: ______________________________

Prefiere su informacion en Ingles o Español?

______________________________ Firma

______________________________ Relacion con el Paciente