

## Smile Questionnaire

**Patient Name:** John Doe

**Birth Date:** 5/14/2011

Please answer the questions below so that we can do our very best to help you

Have you ever experienced any dental trauma? No

Does anyone in your family have gum (periodontal) disease? No

Do you feel that your smile or teeth have changed over the last few years or months? No

Have you noticed that any of your teeth have moved or shifted? No

Are you interested in whiter teeth? No

Is there anything that you would like to change about your smile? No

### Signature

Date of signing 5/14/2020

Relationship to the patient Guardian

Name Jane Roe

IP Address 127.0.0.1

*Signature*