Smile Questionnaire

Charisma Clinic
DENTISTRY & FACIAL AESTHETICS

Patients Name: Date:

When did you last visit a dentist?

Do you experience any of the following?

	YES	NO
Sensitivity (hot/cold/sweet)	☐	☐
Tooth pain or discomfort when chewing	☐	☐
Headaches	☐	☐
Loose or shifting teeth	☐	☐
Are you concerned about freshness of breath	☐	☐

Do you have or have you had any of the following?

	YES	NO
Dentures	☐	☐
Braces	☐	☐
Periodontal (gum) treatment	☐	☐
Veneers	☐	☐
Tooth Whitening	☐	☐

If I could change my teeth I would…

	YES	NO
Make them straighter	☐	☐
Close spaces	☐	☐
Replace fillings with natural tooth coloured fillings	☐	☐
Repair chipped teeth	☐	☐
Replace missing teeth	☐	☐
Replace old crowns	☐	☐
Have a smile makeover	☐	☐

Whitening

	YES	NO
Would you like your teeth whiter?	☐	☐

Facial Cosmetics

	YES	NO
At Charisma Clinic we also offer facial line softening treatments (non-surgical wrinkle reduction). Would you like further information?	☐	☐

Please describe any main dental concerns that you may have that you would like us to know about in the space below: