

Ortho Questionnaire

Patient Details

Title: Miss/Mrs/Mr/Dr other (please specify)

Date of Birth

In order to find the best way to help you please answer to the following questions:

1. My teeth are crooked and difficult to clean Yes..... No
2. My teeth stick out Yes..... No
3. I do not like having my photograph taken Yes No
4. People negatively comment on my teeth Yes..... No
5. I have difficulty in chewing Yes..... No
6. I would like help to achieve my perfect smile Yes..... No
7. I have a special reason why I want straight teeth
now or at some point in the future Yes..... No