

SMILE QUESTIONNAIRE

Take the Smile Test

How we perceive our smile and appearance affects our self-esteem, our moods and how we function in social and business relationships. Analysis of one's smile has both objective and subjective components. The "Smile Test" is designed to focus in on and evaluate your cosmetic concerns.

Objective Analysis

Stand in front of a large mirror and view your smile close-up at first and then step back to get an overall representation.

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|---|---|--|
| Are any of your teeth missing? | <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No |
| Are there spaces between any of your teeth? | <input checked="" type="checkbox"/> Yes | <input type="checkbox"/> No |
| Are your teeth too dark or stained? | <input checked="" type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you have crooked teeth? | <input checked="" type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you have some teeth that are chipped? | <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No |
| Do you have discolored fillings? | <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No |
| Do you have crowns [caps] that show metal? | <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No |
| Do you have crowns [caps] that have dark edges near your gum line? | <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No |
| Is the midpoint between your two front teeth lined up with the middle of your face and nose? | <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No |
| Do any of your teeth appear too fat, too short or too long? | <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No |
| Do the edges of your teeth appear flat and worn? | <input checked="" type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do your eye-teeth [canines] appear too long or out of line? | <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No |
| Do your teeth slant in one direction? | <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No |
| Do your lips cover most of your teeth when you smile? | <input checked="" type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you have a "gummy" smile [too much gums showing]? | <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No |
| Are your gums red and puffy? | <input checked="" type="checkbox"/> Yes | <input type="checkbox"/> No |
| Have your gums receded so that the root surface is visible? | <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No |
| Look at your teeth in the upper right front of your mouth. Is the gum line at a different height when comparing the same teeth on the upper left front? | <input checked="" type="checkbox"/> Yes | <input type="checkbox"/> No |
| Is your face asymmetrical when you smile, so your cheeks and/or lips on one side appear fuller or at different heights? | <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No |
| Stand slightly to the side. Does the biting edges of your upper teeth differ from the curvature of your upper lip? | <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No |

Subjective Analysis

While the objective analysis helps establish how to change your smile, it's your subjective analysis that determines if any changes are necessary. This is based strictly on your own inner feelings and whether or not your smile perception projects character and confidence or projects a poor self-image and/or makes you feel uncomfortable.

Are you unhappy with the appearance of your teeth and smile?

Yes No

Are your teeth too dark or stained? Do you try to avoid being photographed?

Yes No

When being photographed, do you smile with your lips closed?

Yes No

Have you ever been embarrassed when seeing yourself smile in a home video?

Yes No

Do you hold back laughing out loud because of concern for how you will look?

Yes No

Are you inhibited from showing a full smile in front of others, especially strangers?

Yes No

Do you shy away from interacting with groups of people because of your smile?

Yes No

Do you find yourself hiding your smile by turning away or holding something in front of your mouth?

Yes No

When reading magazines and looking at models with beautiful smiles, have you found yourself fantasizing about having their smile?

Yes No

Can you think of an instance where concern for your smile has affected your work?

Yes No

Can you think of an instance where concern for your smile has affected a personal relationship?

Yes No

Have you developed any habits to mask your smile?

Yes No

When you smile, is it forced rather than spontaneous?

Yes No

Are you embarrassed to visit the dentist because of what they may see in your mouth?

Yes No

Does your smile make you feel less confident?

Yes No

Does your smile make you introverted?

Yes No

If you could "wave a magic wand," what changes would you make in your smile?

Describe how a beautiful smile would make you feel.

I would feel more confident if my teeth lined up better and I had a nicer smile.

Most of us make decisions based on our emotions. Evaluate your subjective answers. Do you see a pattern? Do you want to make a change? We can help give you a better, more beautiful smile that can have a powerful impact on your lifestyle and comfort level.

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