Smile Survey

In an effort to provide our patients unsurpassed dental excellence and care, please take a moment in answering the following questions regarding your smile.

1) Rate your smile on a scale of 1-10 with 1 being the least satisfied and 10 being the most satisfied.

   1 2 3 4 5 6 7 8 9 10

2) Which of the following do you feel can be addressed in order to improve your smile score? Please circle all that apply.
   a) Crowded or overlapped teeth
   b) Spaces in between teeth
   c) Narrow smile
   d) Chipped or worn down teeth
   e) Coloration of teeth
   f) Other. Comments: _____

3) Have you noticed your teeth 'shifting' over the years?

   YES NO

4) Is it important to you to keep your natural teeth for life?

   YES NO

5) Have you had orthodontic treatment in the past?

   YES NO

6) Would you be interested in learning more on a highly effective way to improve your smile and oral health using a series of invisible, removable and comfortable aligners?

   YES NO thank you

Thank You For Your Feedback!