LFD Smile Questionnaire

Name____Date______________________

1. Are you happy with your smile?

2. Do you smile with your mouth closed or do you show teeth?

3. What would you change about your smile?

4. What is most important about your dental health? Looks or function?

5. Do you want to our findings in detail or the overall “big picture?”

6. How have your past dental experiences been?

7. We offer laughing gas/nitrous oxide in the office. Would this be something of interest to you?

8. What can we do to make your dental experience the best?