How would you create your smile…….

Name____ **Date**___________________________

Patients often request changes in their bite or face and relief from pain or discomfort. Please help us understand your problem by checking the following information. Please be specific (**circle** words, **backward, left, right etc.)**

TEETH: If your teeth could be changed, how would you like them to change?

- Straighten the front teeth **upper** **lower**
- Straighten the back teeth **upper** **lower**
- Move upper teeth **forward** **backward**
- Move lower teeth **forward** **backward**
- Make the line of the upper teeth more level
- Move the midline of the **upper / lower** to the **right / left**
- **Other**____
  ____

FACE: If your facial appearance could be changed, what would you change?

- Move chin **forward** **backward**
- Move chin to center it **left** **right**
- Move lower lip **forward** **backward**
- Move upper lip **forward** **backward**
- Show **more / less** of my teeth and/or **more / less** gums when I smile
- Make my lips **closer** together
- Make my lips not touch and roll out when my teeth are touching
- **Other**____
  ____

SYMPTOMS: If you want to reduce pain or discomfort, where would it be located? Please be specific about the location; circle the right side, left side or both if they apply.

- In front of my ears **right** **left**
- Below my ears **right** **left**
- Above my ears **right** **left**
- Neck **right** **left**
- Shoulders **right** **left**
- Temples **right** **left**
- Eyes **right** **left**
- Sinuses
- Teeth
- **Other**____
  ____

Anything else?____