

- | | y | n |
|---|--------------------------|--------------------------|
| 1. Are you satisfied with the appearance of your teeth? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Are you self conscious about your teeth when you smile? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Do you wish your teeth were whiter? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you have any irregularly positioned teeth which you dislike? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Do you have discoloured teeth which embarrass you? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Do you wish your teeth were shaped differently? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Do your front teeth have fillings which do not match the colour of your teeth? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Do you wish the fillings in your back teeth were tooth coloured? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Do your gums appear red and swollen, and bleed when you brush them? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Do you suffer from bad breath? | <input type="checkbox"/> | <input type="checkbox"/> |

11. If you could alter your smile what would you most like to change?

.....

.....

.....

.....

12. Rate your scale of nervousness from 1-10 with 1 indicating very relaxed to 10 very anxious