Smile Evaluation

1. Do you like the way your teeth look? Yes □ No □
Explain:_____

2. Are you happy with the color of your teeth? Yes □ No □
Explain:_____

3. Would you like your teeth to be whiter? Yes □ No □

4. Would you like your teeth to be straighter? Yes □ No□

5. Are there spaces between your teeth that you would like closed? Yes □ No □
If so where?_____

6. Have you ever considered orthodontics (braces)? Yes □ No□
Explain:_____

7. Do you like the size and shape of your teeth? Yes □ No □
Explain:_____

8. Do you have missing teeth you would like to replace? Yes□ No□

9. Do you have old silver fillings you would like to replace with tooth-colored fillings?
Yes □ No □

10. Do you wake up with headaches or tension in your neck from grinding? Yes □ No□

11. If you could change anything about your smile, what would it be?

_____
_____

12. Is there anything your dental team should know prior to seeing you?

_____
_____

13. Have you ever been diagnosed with Sleep Apnea? Yes□ No□

14. Have you had an overnight sleep study completed? Yes□ No□

15. Do you wake in the mornings with headaches? Yes□ No□

16. Have you been told that you gasp for air or suddenly stop breathing while sleeping?
Yes□ No□

17. Do you snore? Yes□ No□

18. Do you currently use a CPAP sleep device? Yes□ No□