



Do you like the way your teeth look? Yes No

Explain: _____

Are you happy with the color of your teeth? Yes No

Explain: _____

Would you like your teeth to be straighter? Yes No

Explain: _____

Do you have spaces between your teeth that you would like closed? Yes No

Do you have missing teeth that you would like to replace? Yes No

Explain: _____

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

Explain: _____

If you could change anything about your smile, what would you change? _____

Do you snore, or has anyone told you that you snore? Yes No

Has anyone told you that you stop breathing during the night? Yes No

Do you awake refreshed in the morning? Yes No

Have you ever had a sleep study? Yes No

Have you ever had a CPAP machine prescribed? Yes No