Smile Evaluation

1. Do you like the way your teeth look? Yes No

Explain: _____

2. Are you interested in learning more about sedation dentistry? Yes No

Explain: _____

3. If you could change anything with your teeth and smile, what would you change?

Explain: _____

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

Explain: _____

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

Explain: _____

6. Have your teeth worn down? Yes No

If so, Upper ____ Lower ____ Both ____

7. Do you have sensitivity? Yes No

Where and when: _____

E-mail address: _____

Thank you for taking the time to fill out this questionnaire.

Bite and Jaw Joint

1. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping)_____
2. Do you feel like your lower jaw is being pushed back when you bite your teeth together?_____
3. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods?_____
4. Have your teeth changed in the last 5 years, become shorter, thinner or worn?_____
5. Are your teeth crowding or developing spaces?_____
6. Do you have more than one bite and squeeze to make your teeth fit together?_____
7. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits?_____
8. Do you clench your teeth in the daytime or make them sore?_____
9. Do you have any problems with sleep or wake up with an awareness of your teeth?_____
10. Do you wear or have your ever worn a bite appliance?_____

Thank you for taking the time to fill out this questionnaire