Name:______________________________ Date__________

A Look in the Mirror

1. Are you having any pain or discomfort with your teeth or gums?

   Yes No ____

2. Are any of your teeth chipped, rough, or broken?

   Yes No ____

3. Do you have any dental work or old fillings that are uncomfortable or cause you concern?

   Yes No ____

4. Are you pleased with the general appearance of your teeth and smile?

   Yes No ____

5. Are there any spaces between your teeth that you dislike?

   Yes No ____

6. Are you satisfied with the color of your teeth?

   Yes No ____

7. Do you snore, or have sleep apnea? Yes No

   Do you use a CPAP machine? Yes No

8. What is your primary area of concern that you would like us to address first?

   ____