



### **Occlusion (Bite) Analysis**

1. Do notice pain or discomfort in your face, neck or head? Y or N
2. Do you experience pain in the joint of your jaw? Y or N
3. Do you notice popping or clicking in your jaw when eating? Y or N
4. Do you feel that your teeth touch evenly when you close? Y or N
5. Do you experience headaches? Y or N

### **Sleep Analysis**

1. Do you feel rested in the mornings after a full nights sleep? Y or N
2. Does your spouse/partner complain that you snore? Y or N
3. Do you have episodes of sleep apnea? Y or N
4. Would you be interested in a sleep study? Y or N

### **Oral Health Analysis**

1. Do you feel like you have bad breath? Y or N
2. Do you experience bleeding with brushing and flossing? Y or N
3. Do you have loose teeth? Y or N
4. Are you aware that gum disease can affect your overall health? Y or N
5. Have your ever been told you have gum disease? Y or N

### **Smile Analysis**

1. Are you happy with your smile? Y or N
2. Would you like your teeth lighter? Y or N
3. Has there ever been a time you felt embarrassed to smile? Y or N
4. How would you rate your smile? 1 2 3 4 5 6 7 8 9 10 (1 being not happy 10 being completely satisfied)
5. Is there a celebrity's smile you like? Y or N
  - a. If you answered yes- Who?