Mountain West
FAMILY DENTISTRY

Smile, Sleep & Cosmetic Dentistry Questionnaire

1. How do you feel about your smile?

☐ Very satisfied
☐ Mostly satisfied
☐ Neutral
☐ Somewhat unhappy
☐ Very unhappy

2. What concerns would you like to improve?

☐ Crooked or crowded teeth
☐ Gaps between teeth
☐ Teeth shifting
☐ Discoloration or staining
☐ Clenching or grinding teeth
☐ Jaw pain
☐ Chipped, worn, or uneven teeth
☐ Bite feels off or uncomfortable
☐ I avoid smiling in photos
☐ Teeth Sensitivity
☐ Bad breath
☐ No concerns at this time

3. Have you had orthodontic treatment before?

☐ No
☐ Yes – braces
☐ Yes – clear aligners
☐ Not sure

4. Which services would you like to learn more about?

(Check all that apply)
☐ Clear aligners (Invisalign or similar)
☐ Teeth whitening
☐ Bonding (chips or gaps)
☐ Veneers
☐ Smile makeover
☐ Not interested at this time

5. Dental Sleep section

Do you snore or have you been told you snore? ☐ Yes ☐ No

Do you often feel tired, fatigued, or sleepy during the daytime? ☐ Yes ☐ No

Has anyone observed you gasping for air or stop breathing when you sleep? ☐ Yes ☐ No

Have you ever been diagnosed with sleep apnea? ☐ Yes ☐ No

6. Is there anything specific you would like the dentist to know about your smile goals?

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