## Help us get to know you better!

**Is there anything you would like to change about your smile?**

- ○ Whiter Teeth
- ○ Straighter Teeth
- ○ Missing Teeth
- ○ Gaps
- ○ Nothing

**Do you have Missing Teeth, Loose Fitting Dentures or Partial Dentures?**

- ○ Yes
- ○ No

**Do you snore, have Obstructive Sleep Apnea (OSA) or use a CPAP Machine?**

- ○ Yes
- ○ No

**Have you noticed any of the following?**

- ○ Bad Breath
- ○ Sensitive Teeth
- ○ Receding Gums
- ○ Clenching/ Grinding
- ○ Bleeding when you Brush / Floss

**Would you be interested to learn more about the benefits of BOTOX?**

- ○ Forehead Lines
- ○ Crow's Feet
- ○ Clenching/ Grinding
- ○ Scowl Lines

**Do you have any other dental concerns?** ______________________

______________________

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**Patient Name:** ______________________ **Date:** ____________

**How may we best reach you?**

**Cell# / Email** ______________________

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