DIANA CRAFT, D.D.S.

Smile Evaluation

1. Do you like the way your teeth look? Yes___ No___

   Explain:_____

2. If you could change anything about your smile, what would you change?

   Explain:_____

3. Has dental work made you anxious in the past? Yes___ No___

   Explain:_____

4. Would you like to discuss anti-anxiety/sedation options for dental treatment? Yes____ No____

5. Have you ever been told that you snore? Yes ___ No ___

6. Do you own a CPAP machine for sleep apnea? Yes ___ No ___

   Do you use it? Yes ___ No ___