



Table S1. Awareness of Teeth-Alignment Disorder.

"Are you concerned about alignment of your teeth (appearance of teeth alignment)?"	Yes	No
	<input type="checkbox"/>	<input type="checkbox"/>

Medical History

Please choose the presence or absence of the following disease(s)/disorder(s). When you chose the presence of a history for diseases/disorders, please write the specific name(s) of the disease(s)/disorder(s).

		Presence	Absence	Name of disease(s)/disorder(s)
1	Neuromasucular disease	<input type="checkbox"/>	<input type="checkbox"/>	
2	Cerebrovascular disease	<input type="checkbox"/>	<input type="checkbox"/>	
3	Coronary artery disease	<input type="checkbox"/>	<input type="checkbox"/>	
4	The other vascular disease	<input type="checkbox"/>	<input type="checkbox"/>	
5	Heart disease, arrhythmia, or abnormal electrocardiogram	<input type="checkbox"/>	<input type="checkbox"/>	
6	Hypertention	<input type="checkbox"/>	<input type="checkbox"/>	
7	Respiratory disease	<input type="checkbox"/>	<input type="checkbox"/>	
8	Esophagus, gastrointestinal disease	<input type="checkbox"/>	<input type="checkbox"/>	
9	Liver, gall bladder, pancreatic disease	<input type="checkbox"/>	<input type="checkbox"/>	
10	Renal disease	<input type="checkbox"/>	<input type="checkbox"/>	
11	Hyperuricemia, gout	<input type="checkbox"/>	<input type="checkbox"/>	
12	Diabetes mellitus	<input type="checkbox"/>	<input type="checkbox"/>	
13	Dyslipidemia	<input type="checkbox"/>	<input type="checkbox"/>	
14	Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>	
15	Endocrine disease	<input type="checkbox"/>	<input type="checkbox"/>	
16	Collagen disease	<input type="checkbox"/>	<input type="checkbox"/>	
17	Blood disease	<input type="checkbox"/>	<input type="checkbox"/>	
18	Malignant neoplasm	<input type="checkbox"/>	<input type="checkbox"/>	
19	Allergic disease	<input type="checkbox"/>	<input type="checkbox"/>	
20	Eye disease	<input type="checkbox"/>	<input type="checkbox"/>	
21	Otorhinolaryngologic disease	<input type="checkbox"/>	<input type="checkbox"/>	
22	Skin disease	<input type="checkbox"/>	<input type="checkbox"/>	
23	Bone, joint, muscle diseases	<input type="checkbox"/>	<input type="checkbox"/>	
24	Urologic disease, gynecological disease	<input type="checkbox"/>	<input type="checkbox"/>	
25	The other	<input type="checkbox"/>	<input type="checkbox"/>	