

When was your last visit with a dental hygienist? _____

Were X-rays taken at that time? Yes___ No___

How often do you brush? _____

Do you use a soft toothbrush? Yes___ No___ Electric brush Yes___ No___

Do you floss? Yes___ No___ How often? _____

Do you use any other dental aids? Rubber tip, fluoride, Listerine? Yes___ No ___

Have you ever had orthodontic treatment (braces)? Yes___ No___

Do you have any teeth that are sensitive to hot/cold? Yes___ No___

If yes, which teeth? _____

Are any teeth sensitive to chew or bite with? Yes_____ No_____

If yes, which ones? _____

Are you aware of a grinding or clenching habit? Yes___ No___

Do you wear a sports, night guard or retainer? Yes___ No___

Are you pleased with the appearance of your smile? Yes___ No___

If not, what would you like to change? _____

Are you pleased with their function? (Your ability to chew, eat.) Yes___ No___

Do you sip soda, juice, coffee or tea throughout the day? Yes___ No ___

Do you use candy or mints throughout the day? Yes___ No___

Do you drink bottle, tap or filtered water? _____

Do you smoke? Yes___ No___ . If yes, how much? _____

Do you have any allergies to jewelry, food, medications? Yes___ No___

If yes, what allergy? _____

Who can we thank for referring you to our practice?