**Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Do you now have or have you ever had:**

Toothaches \_\_\_\_\_

Bad Breath \_\_\_\_\_

Pain in Chewing \_\_\_\_\_

Canker Sores \_\_\_\_\_

Bleeding Gums \_\_\_\_\_

Clenching or Grinding Your Teeth \_\_\_\_\_

Pain or Popping in or near your ear \_\_\_\_\_

Frequent Headaches \_\_\_\_\_

Other sore areas in your mouth \_\_\_\_\_

Missing Teeth \_\_\_\_\_

Gum Surgery \_\_\_\_\_

Orthodontic Treatment \_\_\_\_\_

Bridges or Partial Dentures \_\_\_\_\_

Dental Implants \_\_\_\_\_

Root Canal Work \_\_\_\_\_

Has anyone ever instructed you how to:

Brush Yes \_\_\_ No \_\_\_

Floss Yes \_\_\_ No \_\_\_

How often do you brush? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How often do you floss? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When was your last dental visit? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did you have x-rays taken? Yes \_\_\_ No \_\_\_

Do you have regular dental check-ups? Yes \_\_\_ No \_\_\_

**Do you like your smile? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**If not, what would you like to change? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**