



Today's Date _____

PATIENT INFORMATION

Name _____
Last First MI

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 tooth brush? Yes No

Do you use an electric tooth brush? Yes No

Do you use any other dental aids? Yes No

Please circle which of the following: rubber tip fluoride Listerine other: _____

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 when chewing or biting? Yes No

If yes, which teeth? _____

Are you aware of a grinding or clenching habit? Yes No

Do you wear a sports guard, 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 how your teeth function (e.g. 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 bottled, tap or filtered water? _____

Do you smoke? Yes No

If yes, how much? _____

Do you have any allergies to jewelry, food, or medications? Yes No

If yes, what are you allergic to? _____

Who can we thank for referring you to our practice? _____

Responsible party signature

Date