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Name: _____

Date of Last Dental Visit: _____

1. Are you having any dental problems now? Yes No

2. Are your teeth sensitive to any of the following:
   HOT COLD BITING SWEETS

3. Are your teeth any of the following:
   CROWDED SPACED DISCOLORED MISSHAPED

4. If you could change anything about your smile, what would you most like to change?
   _____
   _____

5. Do your gums bleed, feel tender, or irritated? Yes No

6. Do you suffer from bad breath (halitosis)? Yes No

7. What type of food do you snack on? _____

8. How often do you eat these foods? _____

9. What do you drink throughout the day? _____

10. How do you drink them? (Example: Sip throughout day; Drink all at once) _____

11. If you have missing teeth, would you like to learn about "permanent" replacement?
    Yes No

12. Have you noticed or been told that you clench or grind your teeth? Yes No

13. Do you snore or have you been told that you snore? Yes No

14. Are you routinely tired during the day? Yes No

15. Which statement best describes your feelings about visiting the dentist:
    I feel relaxed ***I feel a little anxious*** ***I feel very nervous***

16. Are there any dental procedures that have frightened you or that you are very anxious about?
    _____
    _____
    _____