

Have you ever had problems/ complications with past dental care? Y N If yes, describe: Does your saliva feel thick? Y N N N N N N N N N N N N N	-ull Name			
Orthodontics (parces) Oral surgery (extractions, biopsy) Are you receiving routine dental care? Y N Date of last dental visit: Name of previous dentist: Have any of the following prevented you from seeking dental care? Fear or anxiety Lack of time Lack of firme Lack of firme Cold Pressure (chewing/ biting) Oral surgery (extractions, biopsy) Are your teeth sensitive to: Sweets Hot Cold Pressure (chewing/ biting) Oral surgery (extractions, biopsy) Are your teeth sensitive to: Sweets Hot Cold Pressure (chewing/ biting) Oral surgery (extractions, biopsy) Are your teeth sensitive to: Sweets Hot Cold Pressure (chewing/ biting) Oral surgery (extractions, biopsy) Are your teeth sensitive to: Sweets Hot Cold Pressure (chewing/ biting) Oral surgery (extractions, biopsy) Are your teeth sensitive to: Sweets Hot Cold Pressure (chewing/ biting) Oral surgery (extractions, biopsy) Are your teeth sensitive to: Sweets Hot Cold Pressure (chewing/ biting) Oral surgery (extractions, biopsy) Are your teeth sensitive to: Sweets Hot Cold Pressure (chewing/ biting) Oral surgery (extractions, biopsy) Are your teeth sensitive to: Sweets Hot Cold Pressure (chewing/ biting) Oral surgery (extractions, biopsy) Are your teeth sensitive to: Sweets Hot Cold Pressure (chewing/ biting) Oral surgery (extractions, biopsy) Are your teeth sensitive to: Sweets Hot Cold Pressure (chewing/ biting) Oral surgery (extractions, biopsy Are your teeth sensitive to: Sweets Hot Cold Pressure (chewing/ biting) Oral surgery (extractions, biopsy Are your teeth sensitive to: Sweets Are your teeth sensitive to: Are your teeth straight? Y N Do you have difficulty valing(s) in your mouth? Y N Obes your mouth often feel dry? Y N Do you have difficulty (chewing food? Y N Do you have difficulty (chewing food? Y N Do you have difficulty (chewing food? Y N Do you have difficulty (chewin	Purpose of your visit today:	Indicate any past dental treatment:		
Are you receiving routine dental care? Y N Date of last dental visit: Name of previous dentist: Name of previous dentist: Have any of the following prevented you from seeking dental care? Fear or anxiety Lack of time Lack of funds/ cost No insurance Other: Name of previous dentist: Fear or anxiety Lack of funds/ cost No insurance Other: No insurance Other: Did you ever had problems/ complications with past dental care? Y N What is your current primary water source? City Well Bottle Brush: Fleetric Manual Floss: # times per day Rinse: # times per day Rinse: # times per day Rinse: # times per day Poyou use bleaching products? Y N Describe: Do you use bleaching products? Y N Describe: Dentrures/ Partials How long have you worn them? Any current problems? SMILE EVALUATION 1. Are your satisfied with the appearance of your teeth? Y N D Day on like the color of your teeth? Y N	, , , , , , , , , , , , , , , , , , , ,			
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4. Are there old fillings or other dental work that you don't like the look of? Y N	3. Do you like the color of your teeth?		Υ	 N
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