- How long has it been since your last dental visit? _____

  If less than a year, have you had a cleaning and x-rays within that time? _____

- Please check if you have experienced any of the following:

  __Sensitivity to hot, cold, or biting
  __Have you ever been treated for periodontal disease?
  __Do you think you have bad breath?
  __Do you regularly consume sweets, and/or sweetened beverages?
  __Do you clench or grind your teeth?
  __Pain in your jaw joints?
  __Frequent muscle pain in your face or neck?
  __Frequent or severe headaches?
  __Difficulty opening or closing your mouth, or have painful clicking or popping at your jaw joint?

- If you could change your smile, would you desire any of the following:

  __Whiter smile
  __Straighter teeth
  __Replace silver fillings with tooth colored restorations
  __Have healthier gums
  __Replace missing teeth
  __Have longer teeth

- If you have any additional comments that would familiarize us with your needs, feel free to list them below!
- _____
  _____
  _____