NAME____

Thank you for your time as you fill out this information so we can update your records.

Email Address: ____

Cell Phone: ____

May we remind you of your appointments by email or text? Yes No

In case of emergency contact: ________________________ Phone_____________________

Are you having any dental discomfort? Yes No

If yes explain____

Do you bleed excessively when cut? Yes No

Do you smoke? If yes how many per day? Yes___________ No

Do you drink coffee, tea, red wine, or dark colas? If yes how many? Yes_______No

When was your last dental cleaning? ______________ X-rays? __________________

DO YOU

Snore	Yes	No
Have Sleep Apnea	Yes	No
Use a CPAP	Yes	No
Use a night guard or sleep appliance	Yes	No
Grind/clinch your teeth	Yes	No
Use a TMJ appliance	Yes	No
Have overlapping or crowded teeth	Yes	No
Have spaces	Yes	No
Need braces	Yes	No
Have sensitive teeth	Yes	No
Have loose fitting dentures	Yes	No
Have any issues with your silver fillings	Yes	No
Have white spots on your teeth	Yes	No
Want whiter teeth	Yes	No

Do you have any concerns about the appearance of your teeth? Yes No

If yes, please explain____

Do you have any other dental issues yes no

If yes please explain____