

Continuing Care Appointment Update

Name (please print) _____

Date _____

1. Has there been any changes in your medical history since your last visit with the hygienist?
 Yes No If yes, please explain: _____
 2. Are you taking any new medications?
 Yes No If yes, please explain: _____
 3. Do you have any problems with cold sores or canker sores?
 Yes No If yes, please explain: _____
 4. Are you having any problems or concerns with any dental work recently completed?
 Yes No If yes, please explain: _____
 5. Do you have any questions, concerns, or is there 'anything you don't' like about your smile?
 Yes No If yes, please explain: _____
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6. Do you wish you had whiter teeth?
 Yes No If yes, please explain: _____
 7. Would you like to discuss/evaluate any options to enhance your smile?
 Yes No If yes, please explain: _____
 8. Do you notice your gums bleeding on occasion?
 Yes No If yes, please explain: _____
 9. Have you ever dealt with bad breath problems?
 Yes No If yes, please explain: _____
 10. Do you smoke or chew tobacco?
 Yes No If yes, please explain: _____
 11. Would you like to discuss options to help you quit?
 Yes No If yes, please explain: _____
 12. Do you or any members of your family snore?
 Yes No If yes, who? _____
 13. Have you noticed any sore spots or tender areas in your mouth?
 Yes No If yes, please explain: _____
 14. Rate your brushing habits on a scale 1 → 10:
 poor 1 2 3 4 5 6 7 8 9 10 excellent
 15. Rate your flossing habits on a scale 1 → 10:
 poor 1 2 3 4 5 6 7 8 9 10 excellent
 16. To your knowledge, do you clench or grind your teeth?
 Yes No If yes, please explain: _____
 17. Are there any concerns regarding your overall treatment you would like to share?
 Yes No If yes, please explain: _____
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18. Is there anything we can do to make your experience at Smile for Life Dental better?
 Yes No If yes, please explain: _____