Please tell us about your dental experience since the last time we saw you in our clinic.

**General Questions**

- Has there been any changes in the name or address of your primary dentist? If yes, please include new information.
  - Yes □ No □ If yes

- Have you seen a dentist since your last visit in our clinic? If yes, what did you see the dentist for?
  - Yes □ No □ If yes

- Are you experiencing any tenderness, discomfort or soreness with your teeth, gums, or any area of your mouth?
  - Yes □ No □ If yes

- Do you have any concerns regarding your dental health? If yes, what are your concerns?
  - Yes □ No □ If yes

**Do you have any of the following oral habits?**

- Grinding your teeth □ Yes □ No
- Chewing on lips or cheeks □ Yes □ No
- Clenching your teeth □ Yes □ No
- Chewing on pens/pencils □ Yes □ No
- Biting fingernails □ Yes □ No
- Other □ Yes □ No

**Please check the types of snacks you typically eat in a day.**

- Candy/mints □ If yes
- Cough drops □ If yes
- Cakes/pies/doughnuts □ If yes
- Pop/soda/fruit drinks □ If yes
- Energy drinks □ If yes
- Jellies/jams/syrup/dried fruit □ If yes
- Other □ If yes

**Signatures**

**Signature of Patient, Parent or Guardian:**

X □ Date: __________

**Signature of Student Dental Hygienist:**

X □ Date: __________