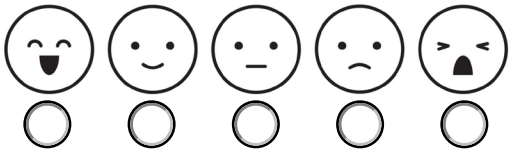
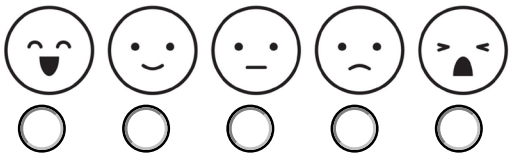
Dental Information

Name_____

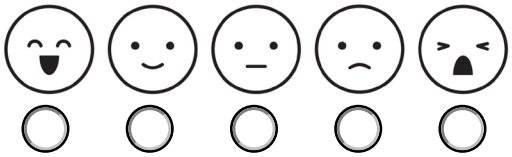
How do you feel about your current oral health?



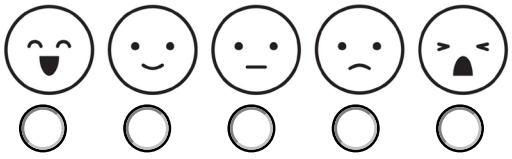
How do you feel about visiting the dentist?



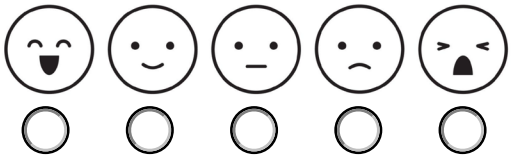
How committed are you to getting cleanings regularly?



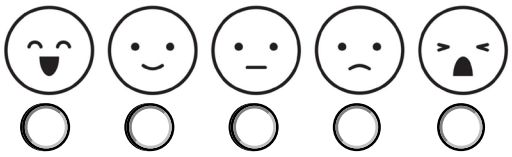
How well do you brush?



How well do you floss?



How motivated are you about keeping/caring for your teeth?



Do you use an electric toothbrush?

○Yes ○No

Do you use a water flosser?

○Yes ○No

Does your toothpaste contain fluoride?

○Yes ○No ○Unsure

Sleep Apnea Evaluation

Do you snore loudly?

○Yes ○No ○Unsure

Do you often feel tired, sleepy or fatigued during the day?

○Yes ○No

Has anyone observed you stop breathing, choking, or gasping during your sleep?

○Yes ○No

Do you have or are you being treated for high blood pressure?

○Yes ○No