CC: CCH:

DO:

PP:

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Brief:

Date Appt Made:	Name:				DOB.				
Padily Home Care Routine: Circle All that apply Electric Toothbrush x day		/ /	Team	Membe	r (initial):				
Padily Home Care Routine: Circle All that apply Electric Toothbrush x day	Last Dental Hygiene	e Visit://		Last FM	IX/PAN:/_	/		_	
Daily Home Care Routine: Circle All that apply Electric Toothbrush x day									
Electric Toothbrush x day	imailed NP info: Y	/ N/	_ Follow	v up Pho	ne Call: Y / N _	/	_/		
Annual Toothbrush x day									
Electric Toothbrush x day	aily Home Care F	Routine: Circle All	that ann	dv					
Manual Toothbrush x day							le rin	se	
Proxabrush Saliva Substitute Other:			_	,					
Are any of your teeth sensitive to: Hot Cold Sweets Biting Chewing (Circle all that apply) Have you ever had: Orthodontic (braces) treatment? Y N Oral Surgery Y N Sleep Apnea treatment? Y N Injury to the mouth or head? Y N Describe Do You have: Difficulty chewing on either side of your mouth? Y N Headaches, neck aches or shoulder aches? Y N Tired jaws, especially in the morning? Y N An occlusal guard or mouth guard? Y N Would you like to discuss levels of comfort that we offer? Nitrous (laughing) gas Y N Premedication Y N Have you ever had an unpleasant dental experience? Y N Would you like to discuss the appearance of your smile? Y N Would you like to discuss the appearance of your teeth, gums, smile? Y N Would you like to discuss the appearance of your teeth, gums, smile? Y N		x day		-	in paoto	-			
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Did any previous dentist recommend dental treatment that was never performed? Y N	Nould you like to di	scuss the appearar	nce of you	ur teeth,	gums, smile?			Υ	N
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