

Welcome to MyDentist!

Our goal is to provide you the best dental treatment possible. Please answer a few questions to help us better meet your dental needs.

SMILE!

EVALUATION

NAME _____ DATE _____

1. What do you want to accomplish during your appointment today? _____

2. What could we do today to make this a positive experience for you? _____

3. If you could change one thing about your smile, what would it be? _____

4. Would you like your teeth to be whiter? _____
5. Do you grind or clench your teeth? If so, does your jaw hurt or give you headaches? _____

6. Do your gums bleed when you brush or floss? _____
7. Have you ever been treated for gum disease? _____
8. Have you been unhappy with any previous dental care? What happened? _____

9. How long has it been since you've seen a dentist? _____
10. Are you missing any teeth? _____ If so, how long have they been missing? _____
11. Are you currently wearing any partials or dentures? _____ If so, how old are they? _____
12. Do you have any crowns or bridges? _____ If so, how old are they? _____
13. How did you hear about MyDentist? _____

Doctor's/Hygienist's Notes: _____

Patient Sleep Questionnaire

Patient Age: _____ Patient Gender: _____

Circle **Agree** or **Disagree** for each statement:

Agree / Disagree	I have been told that I snore
Agree / Disagree	I have been told that I stop breathing when I sleep, although I may have no recollection of this.
Agree / Disagree	I am always sleepy during the day even though I sleep throughout the night.
Agree / Disagree	I have high blood pressure.
Agree / Disagree	I have been told that I sleep restlessly. I am always "tossing and turning" while asleep.
Agree / Disagree	I have difficulty sleeping 3 nights a week or more.
Agree / Disagree	I frequently awaken with headaches.
Agree / Disagree	I tend to fall asleep in inappropriate situations.
Agree / Disagree	Others and/or I have noticed a recent change in my personality.
Agree / Disagree	I am overweight.

If you answered **Agree** to three or more of the above statements, you show symptoms of obstructive sleep apnea, a potentially life-threatening disorder. The dentist may request that you participate in a sleep study for further diagnostic testing. **If you have any questions, please do not hesitate to ask.**

Patient Signature

Date