Patient Name:_____ Date:_____

SAGE DENTAL
Dr. Kyle Siemen

Dental History :

Do you have any dental concerns today? YES_____ NO_____

If you answered yes:

How long has this issue been a concern?_____

Location of problem tooth: Upper Lower Right Left

Sensitivity to: Hot Cold Pressure Aching Throbbing

Other symptoms or concerns:_____

_____

Do you wish your teeth were whiter? YES_____ NO_____

If yes, are you interested in discussing whitening your teeth? YES_____ NO_____

Are you happy with your smile? YES_____NO_____

If no, what would you like changed about your smile?_____

_____

Related dental concerns:

Do you or have you been told you grind your teeth at night? YES_____ NO_____

Are you tired, fatigued, or sleepy most days? YES_____NO_____

Do you or have you been told you snore at night? YES_____ NO_____

Do you or have you been told you cough or gasp for air while sleeping? YES_____NO_____

Have you been diagnosed with Sleep Apnea? YES_____NO_____

If yes, where was your sleep study completed?_____

Is it recommended you wear a CPAP for your sleep apnea?

If yes, how many nights/week do you wear your CPAP?_____