BENAGE
DENTAL CARE

ADDITIONAL INFORMATION

Bio Screen (Oral Cancer Screening): Would you be interested? ☐ YES ☐ NO

TMJ: Do you have any of the following jaw issues? (Please circle all that apply).
Clicking / Popping / Pain / Difficulty Opening or Closing Mouth

Do you have headaches or migraines? ☐ YES ☐ NO
If so, how often? _____

Do you clench or grind your teeth? ☐ YES ☐ NO
If so, how often? _____

Do you snore or have been told you snore? ☐ YES ☐ NO

Have you ever had a sleep study done? ☐ YES ☐ NO

Have you ever been diagnosed with Sleep Apnea? ☐ YES ☐ NO

Do you tend to breathe through your mouth? (mouth breather) ☐ YES ☐ NO

How would you rate your "smile" from 1-10? (1 being worst and 10 being best)
0 1 2 3 4 5 6 7 8 9 10

If there is anything you would like us to be aware of, have questions about, or are interested in more information on, please list them:

_____

_____

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