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PATIENT NAME: _____

1. WHAT IS THE NAME OF YOUR DENTIST?

   _____

2. WHY WERE YOU REFERRED TO OUR OFFICE?

   _____

   _____

3. HAVE YOU HAD PERIODONTAL TREATMENT IN THE PAST?

   _____

   IF YES, WHAT TREATMENT WAS PERFORMED AND WHEN?

   _____

   _____

4. HOW OFTEN DO YOU GET YOUR TEETH CLEANED IN A DENTAL OFFICE?

   _____

5. WHEN WAS YOUR LAST CLEANING?

   _____