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1. What made you select our office? \_\_\_\_\_
  
2. What has been the nature of your past dental experiences? \_\_\_\_\_
  
3. Is there anything you don't like about your smile?  
\_\_\_\_\_
  
4. What bothers you most about your teeth? \_\_\_\_\_
  
5. Do your gums bleed? \_\_\_\_\_
  
6. Do you suffer from frequent headaches? \_\_\_\_\_
  
7. Are any areas of your mouth sensitive? To what? \_\_\_\_\_
  
8. Does food pack between your teeth? \_\_\_\_\_
  
9. Do you wish your teeth were whiter? \_\_\_\_\_
  
10. Have any problems occurred during the course of your past dental care?  
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