DENTAL QUESTIONNAIRE

Name _____

Please answer the following questions so that we may treat you on a more individual basis, providing the care appropriate for your particular needs and desires.

1. Are you having any discomfort at this time? ❑ Yes ❑ No
   Any sensitivity to: cold _____ hot _____ sweets _____ chewing _____

2. Is there any special problem which brought you in today? ❑ Yes ❑ No

3. Date of last dental visit _____

4. Was there any particular reason why you left your previous dentist? _____

5. Does dental treatment make you nervous? ❑ No ❑ Slightly ❑ Moderately ❑ Extremely

6. Is there anything about receiving dental care that concerns you? _____

7. Do you have any of the following:

Bleeding Gums	❑ yes	❑ no	Grind teeth at night	❑ yes	❑ no
Bad Breath	❑ yes	❑ no	Clicking Jaw	❑ yes	❑ no

8. How often do you brush? _____ How about flossing? ❑ daily ❑ sometimes ❑ rarely

9. SEALANTS: Have you had a special coating placed on your back teeth to protect your teeth from decay? ❑ Yes ❑ No

10. If I could change my smile I would make my teeth (check any which apply):

    whiter _____ replace stained front fillings _____ change silver fillings to white _____

    repair chipped teeth _____ close spaces _____ straighten some teeth _____ other _____

11. What I really want from my dental health is: _____

    _____

12. 10 years from now I would like my teeth to be: _____

    _____

13. I think my present state of dental health is: (Circle one) A) Excellent B) Good C) Poor

14. Would you like information about our payment programs ? ❑ yes ❑ no

15. Any additional Comments? _____

    _____

Thank you for providing the above information. Because we strive to deliver dental care in the most comfortable manner possible, your comments are appreciated.

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