DENTAL QUESTIONNAIRE

Name: _____ Date: _____

Correct answers to the following questions will allow us to render optimum health service on an individual basis, providing the care appropriate for your particular needs. Your answers are for our records only and will be considered ***confidential****.*

1. Purpose of dental appointment: _____

2. Are you having discomfort at this time? _____

3. When was your last dental appointment? _____

4. What was done then? _____

5. When was your last dental cleaning? _____ Last dental x-rays_____

6. Have you ever experienced: (please circle)

Extraction complication…….	YES	NO	Clenching or grinding of teeth…..	YES	NO
Sores or lumps in mouth …….	YES	NO	Braces (orthodontia)……..	YES	NO
Difficulty chewing,……..YES		NO	Bleeding gums……	YES	NO
Clicking or locking of the jaw ….	YES	NO	Gum (periodontal) treatment……	YES	NO
Jaw pain……..	YES	NO	Loose teeth ……	YES	NO
Headaches or Migraines…..……	YES	NO	Sensitive teeth …….	YES	NO
Bad Breath……YES		NO	Problems with Novacaine…….	YES	NO

7. Do you have removable dentures or partial dentures? YES NO
   If yes: How do they work for you? _____

9. Do you use (please circle): Water pic, Electric toothbrush, Fluoride rinse, Mouthwash

10. Are you interested in whiter teeth? _____

11. How satisfied are you with the appearance of your smile? _____

12. Has a dentist done anything you disliked in the past? YES NO
    If yes, please describe: _____

13. What would you like to change about your teeth?_____

14. Any other questions or comments about your dental care? _____

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