Dental Questionnaire and History

Please check yes or no to indicate if you have any of the following:

Bad Breath	Yes	No	Lip or cheek biting	Yes	No
Bleeding gums	Yes	No	Loose teeth or broken fillings	Yes	No
Blisters on lips or mouth	Yes	No	Mouth breathing	Yes	No
Burning sensation on tongue	Yes	No	Mouth pain when brushing	Yes	No
Chew on one side of mouth	Yes	No	Orthodontic treatment	Yes	No
Clicking or popping jaw	Yes	No	Pain around ear	Yes	No
Dry mouth	Yes	No	Periodontal treatment	Yes	No
Fingernail biting	Yes	No	Sensitivity to cold	Yes	No
Food collection between the teeth	Yes	No	Sensitivity to heat	Yes	No
Foreign objects	Yes	No	Sensitivity to sweets	Yes	No
Grinding teeth	Yes	No	Sensitivity when biting	Yes	No
Gums swollen or tender	Yes	No	Sores or growths in mouth	Yes	No
Jaw pain or tiredness	Yes	No			

How often do you floss? _____ How often do you brush? _____

Briefly tell us how you feel about your teeth, your smile and dental expectations.

What are your expectations from this office? _____

_____

Are you interested in keeping your natural teeth for the rest of your life? Yes No

If you are already missing some teeth, do you want them replaced? Yes No

Have you ever been told you have periodontal disease (gum disease)? Yes No

Do you like your smile? Yes No

If the answer is no, what changes would you like to see? _____

_____

Rate your smile on a scale of 1-5 with 1 being the lowest score and 5 being the best possible: _____

Are you interested in whitening? Yes No

Do you ever feel anxious or nervous about dental treatment? (circle) Never Sometimes Always

Have you ever had nitrous oxide (laughing gas), general anesthesia or "twilight sleep" during a dental appointment? Yes No

Are you aware of anything that might prevent you from having either basic or cosmetic dental treatment? Yes No

Have your past dental office experiences been positive? Yes No

If no, please explain: _____

_____

Is there anything in particular you would always like us to do for you? Yes No

Explain: _____

Is there anything in particular you would like us never to do? Yes No

Explain: _____

Do you have any dental concerns not listed here that you would like to bring to our attention? Yes No

Explain: _____

_____