

Dental Questionnaire

Name: _____

Date: _____

Please answer the following questions to help us understand your unique perspectives, priorities, and concerns. You can be assured this information is held in confidence.

1. Date of last dental visit: _____ How did you hear about us? _____
2. Previous Dentist: _____ Reason for leaving: _____
3. Have you ever taken an anti-biotic prior to dental treatment? Yes No
4. Have you ever had any problem associated with dental anesthetic? Yes No
5. Are you accustomed to seeing a dentist on a regular basis? Yes No
6. Please rate your comfort level with receiving dental treatment:
 No Problem Slight Moderate Wild Horses Have To Drag Me In
7. Please describe any problems you have had with past dental experiences: _____

8. What is your immediate dental concern? _____

9. These are some things that are important about my dental health and appearance: _____

10. How do you care for your mouth? _____

Please circle the appropriate answer to the following conditions. P=Present C=Concern

Bleeding Gums	P C	Rough Areas	P C	Worn Edges	P C	Clenching / Grinding	P C
TMJ Clicking / Popping Jaw	P C	Food Trap	P C	Cervical Abrasion	P C	Difficulty opening wide	P C
Frequent Headaches	P C	Unpleasant Taste / Breath	P C	Shifting or Changing Bite	P C	Sensitivity to Hot / Cold	P C
Sensitive Teeth	P C	Discolored / Stained Teeth	P C	Cavities / Tooth Decay	P C	Sensitivity to Sweets	P C
Sensitive to: _____		Crowded Teeth / Braces	P C	Burning Tongue / Lips	P C	Sensitivity to Biting	P C
Loose Teeth	P C	Chipped / Broken Teeth	P C	Biting of Cheeks / Lips	P C	Blisters on Lips / Mouth	P C

My <input type="checkbox"/> mouth is very comfortable <input type="checkbox"/> mouth is moderately comfortable <input type="checkbox"/> mouth is uncomfortable	I <input type="checkbox"/> think my dental health is excellent <input type="checkbox"/> think my dental health is good <input type="checkbox"/> think my dental health is poor
I <input type="checkbox"/> think the appearance of my mouth is excellent and would change nothing <input type="checkbox"/> think the appearance of my mouth is satisfactory <input type="checkbox"/> think the appearance of my mouth is unsatisfactory	I <input type="checkbox"/> have put dentistry for myself and family high on my priority list <input type="checkbox"/> have put dentistry for myself and family low on my priority list <input type="checkbox"/> have put dentistry on my list but good care is hard to find
I <input type="checkbox"/> will do anything possible to keep my natural teeth <input type="checkbox"/> want to keep my teeth but I have financial concerns <input type="checkbox"/> expect that I will lose my teeth some day	I <input type="checkbox"/> have chosen the longest lasting dental treatment which initially cost more <input type="checkbox"/> have chosen the least costly treatment dentists have offered <input type="checkbox"/> have rarely gone to the dentist and not completed treatment discussed
I <input type="checkbox"/> have set goals for my dental health <input type="checkbox"/> have never set goals for my dental health <input type="checkbox"/> want to set goals for my dental health	I <input type="checkbox"/> aspire to excellent dental health and repair <input type="checkbox"/> aspire to good dental health and repair <input type="checkbox"/> desire urgent care only