Patients Dental Health Questionnaire

Name: _____

Email: _____

This will help us get to know you as our patient!

Why have you come in to see us today? (pain, checkup) _____

Previous Dentist: _____ Last Visit: _____

Date of last cleaning: _____

Reason for Changing Dentists: _____

What problems have you had with past dental treatment:

_____

Are you nervous about seeing a dentist: Yes__ No __

If yes, please tell us why: _____

Your Dental Hygiene

How often do you brush? _____

Do you floss? Y N How often? _____

Please Circle: Yes: Y or No: N

Y N I clench my teeth during the day or while sleeping

Y N My gums bleed while brushing and flossing

Y N I like my smile

Y N I prefer tooth color fillings

Y N I avoid brushing part of my mouth due to pain

Y N My gums feel tender or swollen

Y N I have problems eating

Y N I have had orthodontics

Y N I have had a facial, jaw, head, neck injury

Y N I want my teeth straight

Y N I want my teeth whiter

What are your dental priorities? _____
(ex: dental Health, financial considerations)