

# DENTAL QUESTIONNAIRE

**NAME** \_\_\_\_\_

Welcome! So that we may provide you with the best possible care, please complete the following information. All information provided is completely confidential.

Date of last dental visit \_\_\_\_\_ Dental cleaning \_\_\_\_\_  
 Previous Dentist's Name \_\_\_\_\_ Phone # \_\_\_\_\_  
 How often do you have dental exams? \_\_\_\_\_  
 How often do you brush your teeth? \_\_\_\_\_ Floss? \_\_\_\_\_  
 What other dental aids do you use?(waterpik, etc) \_\_\_\_\_  
 Do you have any dental problems/concerns now? Yes/no  
 If yes, please explain \_\_\_\_\_

**ARE YOUR TEETH SENSITIVE TO:**

Hot or Cold Yes No  
 Sweets Yes No  
 Biting/Chewing Yes No  
 Bad mouth odors/taste Yes No  
 Cold Sores/blisters/lesions Yes No

**HAVE YOU EVER HAD:**

Orthodontic Treatment Yes No  
 Oral Surgery Yes No  
 Periodontal Treatment Yes No  
 Teeth or Bite adjusted Yes No  
 Splint/Mouth guard Yes No

**DO YOUR GUMS BLEED?** Yes No

Have your parents experienced gum disease/tooth loss Yes No  
 Have you noticed any loose teeth or change in bite Yes No  
 Does food get caught in between your teeth Yes No  
 If yes, where \_\_\_\_\_

**HAVE YOU EXPERIENCED:**

Clicking/popping of jaw Yes No  
 Pain (joint, ear, side of face) Yes No  
 Difficulty opening/closing your mouth Yes No  
 Difficulty chewing on either side of the mouth Yes No  
 Headaches, neck aches, or shoulder aches Yes No

**DO YOU**

Clench or grind while asleep or awake Yes No  
 Bite your lips/cheeks regularly Yes No  
 Hold foreign objects with your Teeth (pencils/pipe) Yes No  
 Have tired/aching jaws, especially in the morning Yes No  
 Smoke/chew tobacco Yes No

**ARE YOU SATISFIED WITH:**

Your teeth's appearance Yes No  
 Your Smile Yes No  
 Would you like to keep your teeth all your life Yes No  
 Do you feel nervous about having dental treatment Yes No  
 Have you had an upsetting dental experience Yes No  
 If yes, please describe \_\_\_\_\_