DENTAL HEALTH QUESTIONNAIRE

Patient Name _____

Patient was Referred By _____

Present Dental Condition

Are you having any pain/discomfort at this time? ○ NONE ○ SOME ○ A LOT

Have you ever had:

- Orthodontic Treatment? ○ YES ○ NO
- Oral Surgery? ○ YES ○ NO
- Periodontal Treatment? ○ YES ○ NO
- Your teeth ground or the bite adjusted? ○ YES ○ NO
- Worn a bite plate/splint or other appliance? ○ YES ○ NO

Have you ever noticed any loosening of your teeth? ○ YES ○ NO

Does food get caught between your teeth? ○ YES ○ NO

Do you have any pain or swelling of your gums? ○ YES ○ NO

Do your gums bleed when you brush your teeth? ○ YES ○ NO

Problems of the Jaw. Have you experienced:

- Clicking of your jaw? ○ YES ○ NO
- Pain (joint, ear, side of face)? ○ YES ○ NO
- Difficulty in opening or closing? ○ YES ○ NO
- Difficulty chewing? ○ YES ○ NO

Improving the appearance of your smile is: ○ High Priority ○ Medium ○ Low

What would you change about your smile (if any): _____

Past Dental Care

Name of Previous Dentist _____

Date of Last Cleaning/Exam _____

Date of Last X-rays _____

In the past, I have gone to the dentist: ○ Regularly ○ Occassionally ○ Emergencies

The last dental treatment I received was for:

- ○ Exam/Cleaning
- ○ Filling/Crown/Other Restoration
- ○ Emergency Care

Home Care

How often do you brush your teeth? _____

Do you:

- Use a flouride rinse? ○ YES ○ NO ○ Sometimes
- Floss your teeth? ○ YES ○ NO ○ Sometimes
- Use whitening agents? ○ YES ○ NO ○ Sometimes
- If yes, what whitening agents do you use? _____

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Habits

Do you:

Clench or grind your teeth (awake or asleep)?	○ YES	○ NO
Hold foreign objects with your teeth? (i.e., pencils, pipe, pins, nails, fingernails)	○ YES	○ NO
Bite your cheeks or lips regularly?	○ YES	○ NO
Mouth breathe while awake or asleep?	○ YES	○ NO

The thought of dental care makes me: ○ Not nervous ○ Slightly nervous ○ Very nervous

Have you ever had an upsetting experience at a dental office or a serious problem with a dental procedure? ○ YES ○ NO

Please explain. _____

_____

_____

Is it important to keep your teeth? ○ YES ○ NO

Are you dissatisfied with the appearance of your teeth? ○ YES ○ NO

Is there anything else about having dental treatment that bothers you? Please explain. _____

_____

_____

_____