



Questionnaire

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To answer yes, please circle the words that apply to your experiences.



Have You Noticed Teeth sensitive to.....?

Cold / Sweets / Pressure / Hot / Chewing / Other _____



Do you have ?

Loose teeth / Bleeding gums / Bad Breath / Receding gums / Dry Mouth / Gum Disease



Do you have any of these jaw symptoms.....?

Jaw pain / Clicking / Popping / Locking open / Locking closed / Difficulty chewing

Tired Jaw Muscles / Accident involving your jaw / Clenching teeth / Grinding teeth / Uneven or unstable bite



Are you concerned about.....?

Yellow teeth / Crooked teeth / Chipped or Broken teeth / Spots or stained teeth

Gaps between teeth / Missing teeth / Difficulty flossing



Do you ever let these linger in your mouth....?

Hard Candy / Mints / Lemons / Pickle juice / Regular sodas / Diet Sodas / Ice Cream / Other



Do you ever ?

Chew Ice or Hard Candy / Chew gum / Use your teeth as tools / Use tobacco / Floss between teeth Use toothpicks / Brush with hard or medium tooth brush / Scrub your teeth hard



In the past have you had.....?

Braces / Gum Surgery / Root Canals / Tooth Whitening / Night Guard

Wisdom Teeth extracted / Other Teeth extracted / Oral Cancer / A Tooth Ache

A Broken Tooth / Deep Cleaning for Gum Disease



About your past dental care

Last cleaning: 3 – 4 months ago / 6 – 12 months ago / within 2 years / more than 2 years

Last x-rays: 3 – 4 months ago / 6 – 12 months ago / within 2 years / more than 2 years

Last exam: 3 – 4 months ago / 6 – 12 months ago / within 2 years / more than 2 years

Frequency of dental visits: every 6 – 12 months / sporadically / seldom / never

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

My main concern is _____

Thank you for selecting our dental health care team! We will strive to provide you with the best possible dental care.

Name Printed

Signature

Date