Patient Questionnaire

(Please complete to help us better meet your Dental needs)

Name:____________________________________Date:_____________________

1. Do you have any concerns about the appearance of your teeth or smile?

____

2. When was the last time you had your teeth cleaned? _____________________

How often do you have your teeth cleaned? ______________________________

3. Do your gums bleed, feel irritated, tender or swollen? If so, where? _________

____

4. How often do you brush and floss your teeth? ___________________________

Do you avoid any part of your mouth while brushing or flossing? If so, where?

____

5. Do you clench or grind your teeth? ____________________________________

6. Are there any areas where you catch or pack food? _______________________

7. Do you ever experience discomfort while biting or chewing? _______________

____

8. Do you ever experience discomfort or pain because of hot, cold or sweets? If so, where? ____

9. Do you smoke or use smokeless tobacco? ______________________________

10. Have you ever worn or considered wearing braces? _____________________

11. Are you missing any teeth? If so, how long? ___________________________

12. Have you ever been told you have Periodontal Disease (gum disease)? ______

If so, have you ever been to a Periodontist? ______________________________

13. Is there anything, not mentioned, that you would like to discuss?

____

____

____

____