New Patient Questionnaire

This questionnaire will help us better understand your dental history and will assist us with any concerns you may have for your future dental treatment.

Dental History

Why are you changing dentists? ____

Do you have any current dental concerns with your mouth? Yes No

Explain: ____

____

Have you ever had a local anesthetic (Novocaine, etc.)? Yes No

Have you ever had an adverse reaction to a local anesthetic? Yes No

Have you ever had any problems associated with previous dental treatment? Yes No

Have you had any injuries or surgeries to your face, mouth, or teeth? Yes No

If yes, explain____

Oral Hygiene/Habits

Have you ever had red, bleeding, or swollen gums? Yes No

If yes, When _______________________? How long? ___________________

Have you ever been told you have gum disease? Yes No

If yes, what treatment was done? ____

How often do you get your teeth cleaned? __________________

Do you currently use an electric toothbrush? Yes No

Do you experienced dry mouth? Yes No

Do you notice that you mouth breathe when you are awake and/or asleep? Yes No

Treatment History

Do you have any pain, popping, clicking, or locking on opening or closing your mouth/jaw? Yes No

Have you ever had orthodontic treatment (braces)? Yes No

Do you have a splint, mouth guard, or night guard? Yes No

If yes, is the material (circle type) Soft Hard

Do you have an Upper Denture or Partial? Yes No

Do you have a Lower Denture or Partial? Yes No

Are you happy with the appearance, feel, function and color of your teeth? Yes No

If no, explain____

If you could change your teeth in anyway, what would you change?

____

____