Patient Questionnaire

Patient ______________________________________ Date _________________

Please tell us the reason for today's dental appointment. ____

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Have you noticed that your gums are red, swollen, or tender? **Y** **N**

Do your gums bleed easily when you brush or floss? **Y** **N**

Have you ever received oral hygiene instructions regarding the care of your teeth and gums? **Y** **N**

Is it important to you that you keep your teeth? **Y** **N**

Have you noticed if any of your teeth are beginning to separate or become loose? **Y** **N**

Are your teeth sensitive to cold or sweets? **Y** **N**

Do you have any teeth that are causing you discomfort? **Y** **N**
If yes, where? ___________________

When is the last time you had a dental cleaning? __________________ Dental treatment? _______________
Where? ___________________

What kind of toothbrush do you use? ____ Manual ____Electric How often to you brush? _____________

What type of bristle do you use? ______Hard _____Medium _____Soft

Do you use floss or any other cleaning aids? _____Yes ____No How often? _______________________

How would you rate your smile on a scale from **1** to **10**, with **10** being perfect? ______________________

Are there things about your smile that you would like to **CHANGE**? ________________________________

What did you like **MOST** about any dentist you have gone to? _____________________________________

What did you like **LEAST** about any dentist you have gone to? ____________________________________

Have you ever been advised that you need dental treatment but chose not to schedule it because of:
_____ Fear _____ Finances _____ Time _____ Other issues

Is there anything else about you teeth you would like to share with us? ________________________________