Dental Questionnaire

Name _____ Date _____

Correct answers to the following will allow us to treat you on a more individual basis, providing the care appropriate for your particular needs. Your answers are for our records only and will be considered confidential.

1. Are you having any discomfort at this time? Yes No
2. Does dental treatment make you nervous? Yes No
3. Date of last dental visit? _____
4. Have you ever been treated for periodontal disease (gum disease, pyorrhea, trench mouth)? Yes No
5. How often do you brush? _____ Brush is: Soft Medium Hard
6. Do you have or have you had any of the following? Please circle Yes or No:
7. Do you suffer with any of the following: Sleep Apnea Snoring

Mouth			**Teeth**		
Bleeding or sore gums	Yes	No	Loose teeth	Yes	No
Unpleasant taste/bad breathe	Yes	No	Sensitive to hot	Yes	No
Burning tongue/lips	Yes	No	Sensitive to cold	Yes	No
Frequent blisters on lips/mouth	Yes	No	Sensitive to sweets	Yes	No
Swelling/lumps in mouth	Yes	No	Sensitive to biting	Yes	No
Ortho treatment (Braces)	Yes	No	Food impaction	Yes	No
Biting cheeks/lips	Yes	No	Clenching/grinding	Yes	No
Clicking/popping jaw	Yes	No	Shifting in bite	Yes	No
Difficulty opening/closing jaw	Yes	No	Change in bite	Yes	No

8. Do you use the following? Brush___Yes ___No Fluoride Rinse __Yes __No Dental Floss___Yes __No
9. Do you like the appearance of your teeth? Yes No
10. Are your teeth stained or chipped? Yes No
11. Are you satisfied with the alignment of your teeth? Yes No
12. If I could show you an easy way to lighten your teeth would you be interested? Yes No
13. What do you fear most about dental care? _____

Consent for Treatment

- I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of _____'s dental needs.
  (Name of Patient)
- Upon such diagnosis I authorize the doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
- I agree to the use of anesthetics, sedatives, and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.
- Lastly, I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1-1/2% late charge (18% APR) may be added to my account.

Patient, Parent or Responsible Party Signature _____ Date _____

OFFICE USE ONLY: *I verbally reviewed the medical/dental information with the patient named herein.*

Initials of the person that reviewed with patient _____ *Date* _____