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Dental Health Questionnaire - General Dental Survey to Design Your Dental Health Goals

Patient Name: _____ Date: _____

1. Are you in any type of dental pain? Yes No Are any of your teeth sensitive? Yes No

If so, describe: _____

2. Do you suffer from bad breath? Yes No

3. Do you grind or clench your teeth? Yes No

4. Do you wake up with soreness or tenderness with your jaws? Yes No

5. Have you ever had gum disease therapy or deep cleanings? Yes No

6. Do you wear any type pf dental appliance, retainer or biteguard? _____

7. How many times a day do you brush your teeth? _____ What type of toothbrush do you use? _____

_____ Does it have soft bristles? _____

How often do you replace your toothbrush? _____

8. How often do you floss your teeth? _____

9. Do you use any mouthwash or rinse? Yes No If so, what kind? _____

10. Please list your primary brand of toothpaste? _____

11. Would you like your teeth to be whiter? _____

12. Are you using any over-the-counter whitening products? _____

We have nitrous oxide/laughing gas available if you desire. Please indicate if you want further information regarding this service. Yes No

Blankets are also available for your comfort. Please feel free to ask for one.

If you could waive a magic wand what, if anything, would you like to change about your teeth

and /or smile? _____

Thank you for taking the time to assist us in getting to know you and your dental needs.