DENTAL QUESTIONNAIRE

Name: _____ Date: _____

Answering the following questions to the best of your ability will allow us to render optimum care specific to your individual dental needs.

What is your immediate dental concern today? (check-up, pain, etc...)_____

_____

When was your last dental appointment? _____

~What was done at that appointment? _____

When was your last dental cleaning? _____ Last dental x-rays_____

Have you ever taken an antibiotic prior to dental treatment? Yes No

Are you experiencing or have you ever experienced:

Bleeding Gums……....	YES	NO	*Gum (periodontal) Treatment*……..…..	YES	NO
Sores or Lumps in Mouth ……..…	YES	NO	*Bad Breath/Unpleasant Taste*…….……	YES	NO
Extraction Complication……	YES	NO	*Extraction of Wisdom Teeth*…….……	YES	NO
Difficulty Chewing……...	YES	NO	*Sensitive Teeth* ……..……	YES	NO
Loose Teeth ……	YES	NO	*Chipped/Broken Teeth*……..……...	YES	NO
Clenching or Grinding of Teeth…….	YES	NO	*Clicking or Locking of the Jaw* ……..…	YES	NO
Jaw Pain……	YES	NO	*Headaches or Migraines*…..……..……	YES	NO
Problems with Novocain……..	YES	NO	*Braces (orthodontia)*……..……...	YES	NO

How would you rate your smile?*

☐ *It's awesome! I love it!* ☐ *I'm happy with my smile but would consider some minor changes*

☐ *It's OK (mildly dissatisfied)* ☐ *I'm unhappy with the appearance of my teeth*

☐ *I'm embarrassed to smile or show my teeth*

What would you like to change about your teeth? _____

Are you interested in whiter teeth? _____

Please describe any problems you've had with past dental experiences if applicable.

_____

Any other questions or comments about your dental care that you would like Dr Lichtsinn to address?

_____

_____