Southpointe Dental
James Lichtsinn, DDS

DENTAL QUESTIONNAIRE

Name: ___________________________________ Date: ______________

Correct answers to the following questions will allow us to render optimum health service on an individual basis, providing the care appropriate for your particular needs. Your answers are for our records only and will be considered ***confidential****.*

1. Purpose of your visit today: ____

2. Are you having discomfort at this time? ____

3. When was your last dental appointment? ____

   ~What was done at that appointment? ____

4. When was your last dental cleaning? ___________________ Last dental x-rays____________

5. Have you ever experienced: (please circle)

Extraction complication…………. YES NO

Clenching or grinding of teeth….. YES NO

Braces (orthodontia)……………. YES NO

Bleeding gums…………………… YES NO

Gum (periodontal) treatment…… YES NO

Jaw pain…………………………. YES NO

Headaches or Migraines…..…… YES NO

Problems with Novocain………. YES NO

Extraction of Wisdom Teeth…… YES NO

Sores or lumps in mouth ………. YES NO

Difficulty chewing……………….. YES NO

Clicking or locking of the jaw …. YES NO

Bad Breath…………………………YES NO

Loose teeth ……………………… YES NO

Sensitive teeth …………………. YES NO

6. Are you interested in whiter teeth? ____

7. How satisfied are you with the appearance of your smile? _______________________________

8. What would you like to change about your teeth? ______________________________________

9. Has a dentist done anything you disliked in the past? YES NO

   If yes, please describe: ____

10. Any other questions or comments about your dental care?

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