New Patient Questionnaire

Name_____ Date_____

When was your last Dental Cleaning?_____

Where X-rays taken at that time? Yes___ No___

How often do you brush?_____

Do you use a soft toothbrush? Yes___ No___

Electric Brush? Yes___ No___

Do you floss? Yes___ No___

How often?_____

Do you use any other dental aids? Rubber tip, Fluoride, mouth wash? Yes___ No___

Have you ever had braces? Yes___ No___

Have you had your wisdom teeth removed? Yes___ No___

Do you have any teeth that are sensitive to hot/cold? Yes___ No___

If yes, which teeth?_____

Are any teeth sensitive to chew or bite with? Yes___ No___

If yes, which ones?_____

Are you aware of a grinding or clenching habit? Yes___ No___

Do you wear a nightguard or retainer? Yes___ No___

Are you pleased with the appearance of your smile? Yes___ No___

If not, what would you like to change?_____

Do you feel like you are able to chew/eat/function well? Yes___ No___

Do you sip soda, Juice, coffee, or tea throughout the day? Yes___ No___

Do you use candy or mints throughout the day? Yes___ No___

What type of water do you drink? Bottled___ Tap___ Filtered___

Do you Smoke? Yes___ No___

If yes, how much?_____

Are you currently experiencing any other significant dental issues? _____

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