

Dental Information Questionnaire

Date _____

Last Name

First Name

Middle Name

Preferred Name

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

Dental History

1. Referred by _____
2. Previous dentist _____
3. How long have you been a patient? _____ Month/Years
4. Date of most recent dental exam _____
5. Most recent xrays _____
6. Date of most recent treatment (other than cleanings) _____
7. I routinely see my dentist every: 3 months 4 months 6 months 12 months Not routinely
8. How would you rate your present state of dental health?
Excellent Good Fair Poor
9. How often do you: Brush _____ Floss _____ Other _____
10. Are you experiencing any discomfort at this time? _____
11. What is your immediate concern? _____

12. Is there anything that would stand in the way of getting the proper dental care that you need? ___

Personal History

1. Does dental treatment make you anxious or fearful? _____
2. Have you ever had an unpleasant dental experience? _____
3. Have you ever had complications from past dental treatment? _____
4. Have you ever had trouble getting numb or a reaction to local anesthesia? _____
5. Have you ever had braces, orthodontic treatment, or your bite adjusted? _____
6. Have you had any teeth removed? _____
7. Do you have any missing teeth that have not been replaced? _____

Smile Characteristics

1. If you could change anything about the appearance of your teeth what would it be? _____

2. Have you ever whitened or bleached your teeth? _____
3. Are you self conscious about your teeth? _____ If yes why? _____

4. Have you been disappointed by the appearance of any previous dental work? _____

Bite and Jaw Joint

1. Do you/would you have any problems chewing gum? _____
2. Do you/would you have any problems chewing bagels or other hard foods? _____
3. Have your teeth changed in the last five years? _____ Become: Shorter Thinner Worn
4. Are your teeth crowding or developing spaces? _____
5. Have you ever been told you grind your teeth? _____
6. Do you have more than one bite (squeeze to make teeth fit together) _____
7. Do you clench (squeeze to make teeth fit together) _____
8. Do you have problems with sleep, or wake up with an awareness of your teeth? _____
9. Do you have problems with your jaw joint? Pain Sounds Limited opening Locking Popping
10. Do you have tension headaches or sore teeth? _____
11. Do you or have you ever worn a bite appliance? _____

Tooth structure

1. Have you had any cavities within the last three years? _____
2. Do you have a dry mouth? _____
3. Have you ever had any of the following:
Toothache cracked filling broken tooth chipped or cracked tooth
4. Do you avoid brushing any part of your mouth? _____

Gum and Bone

1. Have you ever been diagnosed with periodontal disease (Gum disease, pyorrhea, trench mouth)

2. Have you ever been treated for any of the above conditions? If so when? _____

3. Is there anyone in your family with a history of periodontal disease? _____
4. Do your gums bleed when you brush, floss, or eat? _____
5. Are your teeth becoming loose? _____
6. Have you ever noticed an unpleasant taste or odor in your mouth? _____
7. Have you experienced a burning sensation in your mouth? _____

Mouth

Please circle any of the following you have, or have ever had:

Frequent blisters, lips/mouth
Sensitive to hot
Sensitive to sweets

Biting cheeks/lips
Sensitive to cold
Food impaction

Swelling/lumps in mouth
Sensitive to sweets
Denture/partial denture

Please circle the statement that best applies to you:

- | | |
|---|---|
| <p>1. *My mouth is very comfortable.
*My mouth is moderately comfortable.
*My mouth is uncomfortable.</p> | <p>4. *I will do anything to keep my mouth healthy.
*I want my mouth healthy, but have a certain budget of time and money that I am willing to spend.</p> |
| <p>2. *I have set goals for my oral health with a previous dentist.
*I want to set goals concerning my dental health.</p> | <p>5. *I have always done the best that was recommended for my dental health.
*I have not done what dentists have recommended to me.</p> |
| <p>3. *I have put dentistry for myself high on my priority list.
*Dentistry is on my list, but hard to find.</p> | |

Sedation dentistry

1. Has fear kept you from seeking dental care? _____
 2. Would you be interested in sedation dentistry? _____
 3. What do you fear most about dental care? _____
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Tell us about yourself

We like to get to know our patients! Tell us a little about yourself: Hobbies, family, work, etc!


