Dental Information Questionnaire

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 x-rays
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
- Biting cheeks/lips
- Swelling/lumps in mouth
- Sensitive to hot
- Sensitive to cold
- Sensitive to sweets
- Sensitive to sweet
- Food impaction
- Denture/partial denture
Please circle the statement that best applies to you:

1. *My mouth is very comfortable.  
   *My mouth is moderately comfortable.  
   *My mouth is uncomfortable.

2. *I have set goals for my oral health with a previous dentist.  
   *I want to set goals concerning my dental health.

3. *I have put dentistry for myself high on my priority list.  
   *Dentistry is on my list, but hard to find.

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.

5. *I have always done the best that was recommended for my dental health.  
   *I have not done what dentists have recommended to me.

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? ____________________________________________
   ________________________________________________________________________________

Tell us about yourself

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

__________________________________________________________________________________

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