DENTAL QUESTIONAIRE

1. Are you having any discomfort at this time? YES___ NO___
   Any sensitivity to: COLD____ HOT____ SWEETS____ CHEWING____

2. Whom can we thank for referring you? Insurance Co.___ Advertisement___ Current Patient___ _____ Internet___
   (Please provide name)

3. What brought you in today: _____

4. Date of your last Dental Visit: _____

5. Reason you left your previous Dentist: _____

6. Does dental treatment make you nervous? NO___ SLIGHTLY___ EXTREMELY___

7. Is there anything about receiving dental care that concerns you? _____

8. Do you have any of the following: BLEEDING GUMS___ BAD BREATH___ GRIND TEETH AT NIGHT___ CLICKING JAW___

9. How often do you brush? _____ Floss? _____

10. Have you has SEALANTS (a coating placed on your back teeth to protect from decay)? YES___ NO___

11. If I could change my smile, I would make my teeth: (check any which apply)

    Whiter___ Straighten some teeth___ Repair chipped teeth___ Close spaces___
    Replace silver fillings to white___ Replace stained front fillings___

12. What I really want from my dental health is: _____

13. Ten years from now, I would like my teeth to be: _____

14. I believe my present state of dental health is: EXCELLENT___ GOOD___ POOR___

15. Would you like information on our payment program? YES___ NO___

16. Any additional comments or concerns? _____