Dental Questionnaire

(Please circle)

1. Do you prefer to save your teeth? (yes) (no)

2. Do you think your dental health affects your overall physical health? (yes) (no)

3. Are your teeth sensitive, causing pain, or bothering you in any way? (yes) (no)

4. Have you had any bleeding when you brush or floss? (yes) (no)

5. Have you ever had any gum disease problems? (yes) (no)

6. Have you noticed or been told you have bad breath? (yes) (no)

7. Have you ever had an oral cancer exam? (yes) (no)

8. Do you have areas that are difficult to floss or where food catches between your teeth? (yes) (no)

9. Have you noticed any spots or stains on your teeth that concern you? (yes) (no)

10. Are there old fillings or dental work you don't like to see? (yes) (no)

11. If you could change anything about your smile, which of the following might you change?

❑ Whiter ❑ Straighter ❑ Close space(s) ❑ Repair chipped teeth

❑ Replace missing teeth ❑ Less gum showing ❑ Replace old crowns

Explain: _____

_____

12. Please rate the following on a scale of 1 to 10 (10 being highest):

a. How would you rate your overall oral/dental health? 1 2 3 4 5 6 7 8 9 10

b. How would you rate the appearance of your smile? 1 2 3 4 5 6 7 8 9 10

13. Are you looking for: ❑ long-term solutions to problems or ❑ short-term patchwork solutions?

Are there any concerns that would prevent you from going through with treatment at this time? (yes) (no)

If yes, list: _____

_____

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