20 East 46th Street, Suite 1003, New York, NY 10017
212.759.1383

Date: ___________________________

DENTAL QUESTIONAIRE

Name:_________________________________

WHAT IS YOUR IMMEDIATE CONCERN? ____

Previous Dentist ________________________________ Date of most last dental visit ____________________ Date of most recent x-rays _______________

PERSONAL HISTORY

☐ YES ☐ NO 1. Have you ever had trauma to your teeth or face?
☐ YES ☐ NO 2. Are you nervous about dental treatment? How nervous or fearful, on a scale of 1 (least) to 10 (most) [____]
☐ YES ☐ NO 3. Have you ever had complications from past dental treatment or an unfavorable dental experience??
☐ YES ☐ NO 4. Have you ever had trouble getting numb or had any reactions to local anesthetic?
☐ YES ☐ NO 5. Did you ever have braces, orthodontic treatment or had your bite adjusted? Periodontal treatment? A bite plate or mouth guard?
☐ YES ☐ NO 6. Have you had any teeth removed or missing teeth that never developed?

GUM AND BONE

Do you have any concerns about your gums? ☐ YES ☐ NO
If yes:

1. Do your gums bleed or are they painful when brushing or flossing? ☐ YES ☐ NO
2. Have you ever been treated for gum disease or been told you have lost bone around your teeth? ☐ YES ☐ NO
3. Is there anyone with a history of periodontal disease in your family? ☐ YES ☐ NO
4. Have you ever experienced gum recession (gum line pulling away from teeth)? ☐ YES ☐ NO
5. Have you ever noticed an unpleasant taste or odor in your mouth? ☐ YES ☐ NO
6. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple? Any change in your bite? ☐ YES ☐ NO
7. Have you experienced a burning or painful sensation in your mouth not related to your teeth? ☐ YES ☐ NO
8. Any lumps or swellings in your mouth? ☐ YES ☐ NO

TOOTH STRUCTURE

Do you have any concerns or sensitivity with your teeth? ☐ YES ☐ NO
If yes:

1. Have you had any cavities within the past 3 years? ☐ YES ☐ NO
2. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food? ☐ YES ☐ NO
3. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? Any worn edges? ☐ YES ☐ NO
4. Do you have grooves or notches on your teeth near the gum line? ☐ YES ☐ NO
5. Are any teeth sensitive to hot, cold, sweets or on biting? How long does it last? ☐ YES ☐ NO
6. Do you avoid brushing any part of your mouth? ☐ YES ☐ NO
7. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling?
8. Do you frequently get food caught between any teeth? Do you have any areas that are hard to floss? ☐ YES ☐ NO

BITE AND JAW JOINT

Do you have any concerns about your bite or jaw joint? ☐ YES ☐ NO
If yes:

1. Do you have frequent headaches? ☐ YES ☐ NO
2. Does your jaw or facial muscles ever get tired or sore after chewing, sleeping, or with stress, etc.? ☐ YES ☐ NO
3. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping)? ☐ YES ☐ NO
4. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods? ☐ YES ☐ NO
5. Have your teeth changed in the last 5 years, become shorter, thinner or worn? Have you noticed if you grind on your teeth? ☐ YES ☐ NO
6. Are your teeth shifting, becoming more crooked, crowded, overlapped, developing spaces or becoming more loose? ☐ YES ☐ NO
7. Do you have more than one bite, squeeze, or shift your jaw to make your teeth fit together? Does your bite feel comfortable? ☐ YES ☐ NO
8. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? ☐ YES ☐ NO
9. Do you clench your teeth in the daytime or make them sore? ☐ YES ☐ NO
10. Do you have any problems with sleep (i.e. restlessness), wake up with a headache or an awareness of your teeth? ☐ YES ☐ NO
11. Do you wear or have you ever worn a bite appliance? ☐ YES ☐ NO

SMILE CHARACTERISTICS

1. Have you felt uncomfortable about or would like to change anything about the appearance of your teeth? ☐ YES ☐ NO
2. Do you wish your teeth could be whiter? Have you ever whitened (bleached) your teeth? ☐ YES ☐ NO
3. Are you overall satisfied with the appearance of your smile? ☐ YES ☐ NO
   If not, what would you like to change? ____

⇨ ____Date__________________ Relationship to patient _____________
Signature of Patient, parent or guardian
Reviewed by Doctor ____ Date _________________________