BEAUTIFULsmiles™

Dental Questionnaire

Patient's Name_____

Are you in any discomfort? ☐ Yes ☐ No

Any sensitivity to hot, cold, sweets or chewing? ☐ Yes ☐ No

Does dental treatment make you nervous? ☐ Yes ☐ No

Have you experienced any of the following... *(check all that apply)*

☐ Bleeding gums ☐ Grinding or clenching of teeth

☐ Bad breath ☐ Soreness of jaw joint (TMJ)

Do you think dental care affects your health? ☐ Yes ☐ No

Is it important to have your teeth cleaned every 6 months? ☐ Yes ☐ No

Is the brightness of your teeth important to you? ☐ Yes ☐ No

Which of the following do you drink? *(check all that apply)* ☐ Coffee ☐ Sweet Tea ☐ Soda

☐ Sports Drinks (e.g. Gatorade) ☐ Energy Drinks (e.g. Monster)

If you could change your smile, would you like to... *(check all that apply)*

☐ Whiten ☐ Replace crowns that do not match

☐ Straighten ☐ Replace silver fillings

☐ Close gaps ☐ Repair chipped teeth

☐ Decrease sensitivity ☐ Replace missing teeth

☐ Other:_____

On a scale of 1 to 10, with 10 being the highest rating, please rate each of the following questions:

How important is your dental health to you?	1	2	3	4	5	6	7	8	9	10
Where would you rate your current dental health?	1	2	3	4	5	6	7	8	9	10
Where would you like your dental health to be ranked?	1	2	3	4	5	6	7	8	9	10
How important is it to preserve or keep your teeth?	1	2	3	4	5	6	7	8	9	10

Date of your last dental cleaning?_____

What did you like best about your previous dental office?_____

What did you like least about your previous dental office?_____

What is the most important thing to you about your future smile and dental health?_____

What is the most important thing to you about your dental visit today?_____

Any additional comments or information you would like to share with us?