DOVE FAMILY DENTISTRY

Patient Questionnaire

Name: _____ **Date:** _____

Our practice is committed to providing each of our patients with individualized care consistent with their specific needs and values. By answering the following questions candidly, you will help us better understand your dental concerns and expectations.

1) Who referred you to our office? _____

Previous Dentist: _____ City: _____ Approximate date of last visit: _____

2) Does dental treatment make you nervous? __ No __ Slight __ Moderate __ Extreme

Would you like nitrous oxide (laughing gas) for routine dental work? ___ Yes ___ No ___

3) Is anything currently bothering: __ No / If yes, explain _____

_____

_____

4) How often do you use the following?

☐ Toothbrush (manual or electric): ☐ DAILY ☐ WEEKLY ☐ RARELY

☐ Dental floss: ☐ DAILY ☐ WEEKLY ☐ RARELY

Other oral hygiene device:_____ ☐ DAILY ☐ WEEKLY ☐ RARELY

5) Do you have or have you ever had any of the following?

☐ Orthodontic treatment (braces)?

☐ TMJ / jaw issues?

☐ Clenching / grinding?

☐ Night Guard / retainer

☐ Teeth sensitive to hot, cold, sweet?

☐ Bleeding or sore gums?

☐ Unpleasant taste or bad breath?

☐ Loose/ mobile teeth?

6) Have you ever been diagnosed or treated for periodontal (gum) disease?

☐ Yes ☐ No Approximate date of your last "deep cleaning" if known: _____

7) Do you wear a night guard? ☐ Yes ☐ No

(Please bring night guard/retainers with you to ALL dental appointments).

8) Have you had complications with any dental procedures in the past?

Explain: _____

_____

9) Have you ever had a reaction to local anesthetic?

☐ Heart Racing ☐ Dizziness ☐ Nausea ☐ Vomiting ☐ Fatigue

10) Have you ever had difficulty getting numb?

Explain: _____

11) Are you aware of any dental treatment left incomplete?

Explain: _____

12) Overall are you happy with your smile? ☐ Yes ☐ No

If NO, what would you like to change? _____

_____

_____

Is there any other information you would like us to know? _____

_____

Print Name: _____ Signature: _____ Date: _____