First Visit Questionnaire

Patient Name: ______________________________________ Date: _____________________

Who should we thank for referring you? ____

Chief Concerns: Is there anything in particular that you would like for us to check today?

Sensitivity to: ☐ *Hot* ☐ *Cold* ☐ *Sweets* ☐ *Pressure*

Other: ____

Are your teeth comfortable for chewing and biting? ____

Do your gums bleed or hurt? ☐ *Yes* ☐ *No*

Do you experience tired jaws, headaches especially in the morning? ___________________________________

Review Dental History:

How often have you had dental examinations in the past? ____

When was your last dental visit? ___________________ Treatment Received? ________________________

Are you happy with your smile? ☐ *Yes* ☐ *No*

What would you like to change with your smile? ____

Were you pleased with previous dental treatment? (Any problems?) __________________________________
____

Do you feel nervous about having dental treatment? (Any upsetting experiences?) _________________________
____

Is there anything else about having dental treatment that you would like us to know? _____________________
____

Have you ever had: ☐ *braces* ☐ *oral surgery* ☐ *periodontal tx* ☐ *serious injury to mouth/head*

How often do you: *Brush*___/day *Floss*___/day

Are you interested in whitening your teeth? ☐ *Yes* ☐ *No*