Name: _____ DOB: _____

Dental Questionnaire

1. Name, Address & Phone of Previous/Referring dentist: _____
2. When did you last visit a dentist? _____
3. What was done at that time? _____
4. Why did you leave that dentist? _____
5. Date of your last cleaning _____
6. Date of your last exam _____
7. Date of your last full series of x-rays _____
8. Date of last cavity detection (bitewing) x-rays _____
9. Has any dental treatment been recommended to you that you have not done? ☐ Yes; Describe: ☐ No
10. Are you aware of any dental problems? ☐ Yes; Describe: ☐ No
11. What do you feel is the present condition of your mouth? _____
12. Do your gums bleed while brushing or flossing? ☐ Yes ☐ No
13. Have you ever been treated for gum disease? ☐ Yes; what was done:_____ ☐ No
14. Are your teeth sensitive to any of the following: ☐ Sweet ☐ Cold ☐ Heat ☐ Pressure ☐ Nothing
15. Are you happy with the appearance of your smile? ☐ Yes ☐ No; Explain: _____
16. Are you concerned with bad breath (malodor)? ☐ Yes ☐ No
17. Are you concerned with snoring or sleep apnea? ☐ Yes ☐ No
18. Are you concerned with grinding your teeth (bruxism)? ☐ Yes ☐ No
19. Are you aware of possible TMJ problems (does your jaw make noise or lock up)? ☐ Yes ☐ No
20. Have you had any injury to your teeth, jaw or face? ☐ Yes; Describe:_____ ☐ No
21. Do you have dental anxiety? ☐ Yes ☐ No
22. If yes, is there anything you are aware of that helps alleviate the anxiety? _____

Additional Comments

Is there anything else that would be helpful for your dentist to know? ☐ Yes ☐ No

Name: _____ DOB: _____

Medical Questionnaire

1. Emergency Contact Name and Phone #: _____
2. Primary Physician Name, Address and Phone: _____
3. Referring Physician Name, Address and Phone: _____
4. Are you in good health? ☐ Yes ☐ No
5. When was your last physical examination? _____
6. Are you currently under care of a Physician? ☐ Yes; Condition: ☐ No
7. Have you had any serious illness, operation, accident or been hospitalized? ☐ Yes; Describe: ☐ No
8. Has there been any change in your general health in the past year? ☐ Yes; Describe: ☐ No
9. Are you currently taking any medication other than listed earlier, including OTC, vitamins or herbal remedies? ☐ Yes; Please provide a list. ☐ No
10. Have you had previous problems with general or local anesthesia? ☐ Yes; Describe: ☐ No
11. Do you have any allergies besides what was listed in the Patient Medical Information Section? ☐ Yes; Describe: ☐ No

Women Only

12. Are you pregnant or is there a chance you may be pregnant? ☐ Yes- Due Date_____ ☐ No
13. Are you currently nursing? ☐ Yes ☐ No

Family/Personal/Social History

14. Mother Healthy? ☐ Yes ☐ No; Explain:_____
15. Father Healthy? ☐ Yes ☐ No; Explain: _____
16. Do you now or have you ever used:

Tobacco/Chew/e-cigarettes	☐ No	☐ Yes	Frequency _____	Number of years _____	Quit Date_____
Alcohol	☐ No	☐ Yes	Frequency _____	Last Drink _____	Quit Date _____
Recreational/Street Drugs	☐ No	☐ Yes	Frequency _____	Number of Years _____	Quit Date _____

Additional Comments

By signing below, I certify that all of the above information is true to the best of my knowledge.

_____ _____

Patient's Signature (Parent/Guardian) Date Dentist/Doctor's Signature Date

INFORMATION UPDATED

_____ _____

Patient's Signature (Parent/Guardian) Date Dentist/Doctor's Signature Date