New Patient Questionnaire

Patient Name: _____ Birth Date: _____

At All Smiles Family Dentistry, we pride ourselves in comprehensive dental care. We have a series of questions we would like you to answer to help us understand your treatment goals.

			Please explain
Have you ever had braces or orthodontics?	Yes	No	_____
Do you have a retainer?	Yes	No	_____
Have you had your wisdom teeth removed?	Yes	No	_____
Do you have a history of periodontal therapy or deep cleanings?	Yes	No	_____
Do you have a history of gum surgery?	Yes	No	_____
Have you ever had any trauma to your teeth and/or jaws?	Yes	No	_____
Do you have or have you had pain, popping, or clicking in your jaw joints?	Yes	No	_____
Have you had any unpleasant dental experiences?	Yes	No	_____
Do you have any pain or areas of concern?	Yes	No	_____
Do you have any sensitivity to hot or cold?	Yes	No	_____
Are you happy with your smile?	Yes	No	_____
Are you interested in saving your teeth?	Yes	No	_____

When was the last time you were at the dentist? _____ Who was your dentist? _____

Please list any oral hygiene products that you currently use. (Colgate Total, Listerine, Crest Pro Health, Sonicare, etc.):

_____

How often do you brush your teeth? _____

How often do you floss your teeth? _____

How often do you use mouthwash? _____

What type of toothbrush do you use?(manual, power/electric, etc.) _____

Are you a:

_____ non-smoker (never smoked)

_____ current smoker; _____ pack per day; interested in quitting Yes No ; tried quitting in past Yes No

_____ former smoker; date quit _____ ; _____ years smoked

Do you use smokeless tobacco? Yes No

Why did you choose to come to our office?

Candy Buy Back Live Nearby School Visit Commercial Internet Other: _____

Recommended by friend or family member: _____
(patient name)

Is there anything else you would like us to know about your dental health that we did not cover in the above questions? _____

_____

_____

_____

_____