

New Patient Dental Information Sheet

Patient Name _____ Date _____

1. Chief complaint/reason for visit:

2. If tooth pain, please rate 1 (minimal pain)-10 (worst pain): _____
List areas sensitive to: cold _____ hot _____ sweets _____ pressure _____
List areas that you notice loose teeth: _____
3. Date of last exam and professional cleaning? _____
If more than 2 yrs, why? _____
4. Have you ever been treated for periodontal/gum disease? _____
5. Have you had braces before? _____
If yes, are you still wearing your retainer? _____
6. Do you have missing teeth that you would like to replace? _____
7. Have you had any problems with your jaw joints? _____
Have you noticed changes in how your teeth come together? _____
Have you ever had difficulty opening or closing your mouth? _____
Did you ever experience any trauma to your lower face? _____
8. Does food get packed between certain teeth and which area? _____
9. Are the biting edges of your teeth chipped, uneven, thin, or worn down? _____
10. Do you or your spouse snore at night? _____
If yes, have you been diagnosed with sleep apnea and when? _____
11. Have you ever had any unpleasant experiences associated with previous dentistry?

12. How many times a day do you brush and what type (soft/med/hard)?

13. How often do you floss a week? _____
14. Do your gums bleed or feel sore when you brush or floss? _____
15. Do you smoke? _____
If yes, are you interested in assistance with quitting? _____
16. Have you noticed any problems with bad breath and what have you tried?

17. Would you like to enhance the color and brightness of your smile? _____

Dental Satisfaction Level

Please check the appropriate boxes.

1. My mouth is... very comfortable
 moderately comfortable
 uncomfortable
2. I ... am satisfied with the appearance of my smile
 am dissatisfied with the appearance of my smile.
3. I ... have set goals for my oral health with a previous dentist.
 want to set goals concerning my dental health.
4. I ... have put dentistry for myself and my family high on my priority.
 have put dentistry for myself and my family low on my priority.
 dentistry is on my list, but it is hard to find priority.
5. I think my present state of dental health is excellent good poor
6. How does your smile make you feel? Confident? _____
7. Have you ever held back a laugh because you felt uncomfortable with your smile? _____
8. Looking into a mirror, please list anything you would want to change about your smile.

9. These are the things that are important to me about my dental health:

10. What I expect from my dentist:

