DENTAL QUESTIONNAIRE

ARBUTUS NORTH DENTAL

DENTAL HISTORY: **PATIENT NAME:** _____

- When was your last dental visit? _____
- When did you last have dental x-rays? _____
- When was your last dental cleaning? _____
- Name of Previous Dentist: _____ Phone Number: _____
- How often do you brush your teeth? _____
- How often do you floss your teeth? _____
- What are your goals and/or priorities for your oral health? _____

_____

	YES	NOT SURE/MAYBE	NO
Have you been seeing a dentist regularly?	❑	❑	❑
Do any of your teeth ache?	❑	❑	❑
Have you ever been advised to take antibiotics before dental appointments?	❑	❑	❑
Do your gums bleed when you brush?	❑	❑	❑
Do you have any pain when you chew?	❑	❑	❑
Do you feel that you have bad breath?	❑	❑	❑
Are there any growths or sores in your mouth?	❑	❑	❑
Do you catch food in or around any of your teeth or gums?	❑	❑	❑
Do you grind or clench your teeth?	❑	❑	❑
Are any of your teeth moving or becoming loose?	❑	❑	❑
Do you have any pain or clicking in your jaw joints?	❑	❑	❑
Have you ever been in a vehicle accident or experienced any blows to your jaw?	❑	❑	❑
Have you ever had any implant surgery in one or both of your jaws?	❑	❑	❑

- If you answered "yes" to the last question, who performed the surgery and when was it done? _____

_____

- Are you being followed up by a dental specialist? _____
- Have you previously had any of the following dental treatments:

❑ Orthodontic Treatment (braces) ❑ Periodontic Treatment (gums/bone) ❑ Oral Surgery (extractions)

❑ Endodontic Treatment (root canal) ❑ Crowns or Bridges ❑ Porcelain Veneers

❑ Tooth Whitening ❑ Bonding

- While having previous dental treatment, have your ever:

❑ Fainted? ❑ Had abnormal bleeding? ❑ Other complication?

SMILE EVALUATION:

- Do you like the way your teeth look? ❑ YES ❑ NO
  Explain: _____
- Are you happy with the colour of your teeth? ❑ YES ❑ NO
  Explain: _____
- Would you like for your teeth to be whiter? ❑ YES ❑ NO
  Explain: _____
- Would you like your teeth to be straighter? ❑ YES ❑ NO
  Explain: _____
- Do you have spaces between your teeth that you would like closed? ❑ YES ❑ NO
  If so where: _____
- Would you like your teeth to be longer? ❑ YES ❑ NO
  If so, Upper _____ Lower _____ Both _____ ?
- Do you like the shape of your teeth? ❑ YES ❑ NO
  Explain: _____
- Do you have missing teeth that you would like to replace? ❑ YES ❑ NO
  Explain: _____
- Do you have old silver fillings that you would like to replace with tooth-coloured fillings? ❑ YES ❑ NO
  Explain: _____
- Do you feel you show too much gum when you smile? ❑ YES ❑ NO
  Explain: _____
- If you could change anything about your smile, what would you change? _____
  _____

Patient/Parent/Guardian Signature: _____ Date: _____

Dentist Signature: _____ Date: _____

DENTIST'S NOTES