

DENTAL SMILE & QUESTIONNAIRE

1. When was your last dental visit and the reason for it? _____

What is the reason for your visit today? _____

- | | Yes | No |
|--|--------------------------|--------------------------|
| 2. Have you ever had an unfavorable reaction to local anesthetics (Novocain)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you had any serious trouble associated with previous dental treatment? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you smoke tobacco? How much? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Do your gums bleed when you floss or brush your teeth? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Do you have any problems with halitosis (Bad breath)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you ever been told before that you have gum disease (gingivitis or periodontitis)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Do you grind or clench your teeth? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Have you ever been told to wear a "Nightguard", or do you wear one now? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Are your teeth sensitive to hot/cold or sweets? | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Do you have a problem with food getting stuck between your fillings or restorations? | <input type="checkbox"/> | <input type="checkbox"/> |

-
- | | | |
|---|---|---|
| 12. Are you happy with your teeth and smile? | □ | □ |
| 13. Would you like your teeth to be aligned or straighter? | □ | □ |
| 14. Would you like your teeth to be whiter? | □ | □ |
| 15. Would you like more information on whitening procedures? | □ | □ |
| 16. Are there any damaged teeth or restorations that you would like replaced? | □ | □ |

If yes, please indicate which area of your mouth they are in: _____

- | | | |
|--|---|---|
| 17. Are there missing teeth or a tooth that you would like to be replaced? | □ | □ |
| 18. Are you interested in any cosmetic dental procedure, such as veneers? | □ | □ |

Please give us any other information which you think may help us in providing you with better dental care:

Patient Name

Signature (patient/guardian)

Date