Dental History Questionnaire

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Name_____ **E-Mail:**_____

Home # _____ **Cell #** _____ **Work #**_____

Please check any question that you would answer "YES"

☐ Are you apprehensive of dental treatment ?

☐ Does food catch between your teeth?

☐ Are you teeth sensitive when chewing?
If so, where?_____

☐ Are your teeth sensitive to cold?
If so, where?_____

☐ Are your teeth sensitive to hot?
If so, where?_____

☐ Are your teeth sensitive to sweet?
If so, where?_____

☐ Do you have any burning in your lips or tongue?

☐ Do you bite your cheek or tongue frequently?

☐ Do your gums bleed easily?

☐ Do your gums feel swollen or tender?

☐ Have you ever been treated for gum disease?

☐ Do you have bad breath?

☐ Have you noticed a change in your bite or shifting of your teeth?

☐ Are any of your teeth loose?

Why are you now seeking dental treatment?
_____
_____
_____

When was your last visit to the dentist?
_____

☐ How often do you brush?_____

☐ How often do you floss? _____

☐ Do you grind or clench your teeth?

☐ Do you have earaches or pain in the front of your ears?

☐ Do you have a tempormandibular (TMJ) disorder?

☐ Are you unable to open your mouth wide?

☐ Have you had trauma to the jaw?
If so, when?_____

☐ Do you have any clicking or popping in your jaw?

☐ Have you had orthodontic treatment? (braces)

☐ Are you a habitual gum chewer?

☐ Do you take fluoride supplements?

☐ Are you unhappy with the appearance of your teeth?

☐ Do you like your smile?

☐ Are you concerned with the oral health effects of Menopause?

☐ Are you interested in Holistic/ Biocompatible dental options for your treatment?

☐ Are you interested in removing your mercury fillings safely?

☐ Are you interested in the supplements associated with mercury toxicity due to mercury containing fillings?

Name of Insurance:_____

Member ID #: _____

Group Number: _____