The DENTAL COLLECTIVE

Dental Questionnaire

Name of Previous Dentist		
Phone Number		
Date of your last Cleaning		
Date of Last Exam		
Date of Last radiographs and type		
Treatment (other than a cleaning) performed at last dental appointment		
Do your gums bleed while brushing or flossing?	Yes	No
Are your teeth sensitive?	Yes	No
Do you frequently get blisters, ulcers, or sores on your lips or in your mouth?	Yes	No
Have you had burning of your tongue/cracking at the corners of your mouth?	Yes	No
Do you chew tobacco?	Yes	No
Do you smoke marijuana or tobacco?	Yes	No
Have you had any head, neck, or jaw injuries?	Yes	No
Do you notice popping, clicking, or soreness of the jaw?	Yes	No
Do you clench or grind your teeth?	Yes	No
Do you wear a nightguard or sportsguard? When:	Yes	No
Have you ever had orthodontic treatment?	Yes	No
Do you wear dentures or partials? Age of device:	Yes	No
Are you having issues with your mouth currently?	Yes	No
Are you happy with your smile?	Yes	No
Do you have problems with teeth/fillings problem?	Yes	No
Do you regularly have ever been told you have pyorrhea/periodontal disease?	Yes	No
Do you have difficulty in opening your mouth widely?	Yes	No
Do you have an unpleasant odor in your mouth?	Yes	No
Does food catch in between your teeth?	Yes	No
Do you want to learn to control your dental disease and retain your teeth?	Yes	No
Additional Comments		

By signing below, I certify that all of the above information is true to the best of my knowledge.

_____ _____ _____

Print Name **Signature** **Date**

Reviewed By:_____ _____ _____

Print Name **Signature** **Date**