**DENTAL QUESTIONNAIRE**

Christian Name:
Surname:
Address:
Male or Female:
Date of Birth:

**Contact Details**
How would you like to be addressed in our dental practice? (i.e. first name)..........................................
Phone number(s)......................................................................................................................................
How did you hear about us?....................................................................................................................
How can we meet your expectations?.....................................................................................................

**Visit History**
What would you like us to do for you?........................................................................................................
How long since your last dental visit?........................................................................................................
Is there any aspect of attending the practice that concerns you?................................................................
Is there any outstanding work that needs completion? If so, we can prioritise it.................................

**Dental History**
Are your teeth sensitive to hot and cold? Y N
Or painful when you bite? Y N
Are there areas in your mouth where food gets trapped? Y N
Do you have missing teeth that you would like to replace? Y N
If you wear dentures are you happy with them? Y N

**Cosmetic**
Are you happy with your smile? Y N
Is there any part of your smile you would like to change? Y N
Are you satisfied with the colour of your teeth? Y N
Are you happy with the spacing/alignment of your teeth? Y N
Do you have unsightly fillings you would like to change? Y N
Are you interested in facial rejuvenation? Y N

**Gum Health**
Do you brush your teeth? Y N
How many times a day do you brush your teeth? 1 2 3
Do you suffer with bad breath? Y N
Do you have any loose teeth? Y N
Do you use dental floss other or interdental cleaning aids? Y N
Have you seen a dental hygienist before? Y N

**Jaw Health**
Do you grind, squeeze or clench your teeth together? Y N
Do you suffer with clicking, cracking and/or pain in your jaw joints? Y N
Do you suffer with headaches or migraine? Y N

(Please circle)

**Patient Signature**.............................................................................................................................
**Dentist signature**..............................................................................................................................