

Dental Questionnaire

 Last First Middle Nickname

Correct answers to the following questions will allow your dentist to treat you on a more individual basis, providing the care appropriate for your particular needs. Your answers are for **our** records only and will be considered confidential.

1. Are you having any discomfort at this time? Yes No
 If Yes, what? _____
2. Have you ever had any serious trouble associated with previous dentistry?. Yes No
 If Yes, what? _____
3. Does dental treatment make you nervous?. . . . No Slightly Moderately Extremely
4. Date of last dental visit: _____
5. Have you ever been treated for periodontal disease?. Yes No
 (gum disease, pyorrhea, trench mouth)
6. How often do you brush? _____ Floss? _____
 Brush is: Soft Medium Hard
7. Do you have or have you ever had any of the following:

MOUTH

- Bleeding, sore gums. Yes No
- Unpleasant taste / bad breath. . . Yes No
- Burning tongue / lips. Yes No
- Frequent blisters, lips / mouth. . . Yes No
- Swelling / lumps in mouth. Yes No
- Orthodontic treatment (braces). . Yes No
- Biting cheeks / lips. Yes No
- Clicking / popping jaw. Yes No
- Difficulty opening/closing jaw. . . Yes No

TEETH

- Loose teeth. Yes No
- Sensitive to hot. Yes No
- Sensitive to cold. Yes No
- Sensitive to sweets. Yes No
- Sensitive to biting. Yes No
- Food impaction. Yes No
- Clenching / grinding. Yes No
 If so, when? _____
- Shifting or change in bite. Yes No

8. Do you use the following?. . . Fluoride rinse Other dental aids _____
9. These are the things that are important to me about my dental health: _____

Our office is dedicated to the concept that all people should have the right to retain their natural teeth for a lifetime. Preventive measures, high quality care and good cooperation, combined with timely treatment, make it possible for most people to retain their natural teeth with optimum comfort, function and appearance. My staff and I are dedicated to this concept. With your help and cooperation we will do everything we can to help you reach your goals for dental health.

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have a change in my health or if my medicines change, I will inform the doctor at the next appointment without fail.

I hereby authorize Dr. Sarah Aylard and/or her staff to perform any and all discussed treatment for me, and consent to such methods drugs and agents as may be indicated in connection with my dental care. This consent shall remain in effect until canceled in writing. Furthermore, I agree that I am responsible financially and shall faithfully compensate Dr. Aylard for any and all dental services rendered.

Signature: _____ Date: _____

PLEASE NOTE: Payment is expected for services rendered at the time of the first visit. Financial arrangements for subsequent treatment may be made following the diagnosis.