



DENTAL HEALTH QUESTIONNAIRE

Purpose for initial visit? _____

How long ago was your last dental visit? _____

YES NO Are you satisfied with the function and feel of your teeth?

YES NO Do you brush more than once a day?

YES NO Do you use dental floss?

YES NO Do your gums bleed when brushing or flossing?

YES NO Have you noticed your gums receding?

YES NO Are your teeth sensitive to cold, hot, or sweets?

YES NO Do you frequently consume food and beverages between meals?

YES NO Do you drink soda, energy drinks, or juice?

YES NO Were any teeth in your mouth extracted?

YES NO If so, would you like to replace them?

YES NO Are you satisfied with the appearance of your teeth and smile?

YES NO Would you like to have whiter teeth?

YES NO Would you be interested in discussing cosmetic options to improve your smile?

YES NO Do you frequently get headaches / migraines?

YES NO Do you ever have sore muscles in face, temples or jaw area?

YES NO Do you ever clench or grind your teeth?

YES NO Are your front teeth worn down?

YES NO Are you conscious of the way your teeth come together?

YES NO Do you notice any clicking, popping, or soreness of the jaw?

YES NO Have you ever had an injury to your jaw or face?

Personal preferences

If / when dental treatment is performed with Dr. Andler would you like to use:

YES NO Music headphones (any particular radio station _____)

Is there anything we can do during your visits to make it a more comfortable and enjoyable experience? _____