

Examination Questionnaire

Patient Name _____ Date: _____

1. What is the reason for today's visit? _____
2. Why did you leave your last dentist? _____
3. How long since you last dental exam? _____
4. Were x-rays of ALL teeth taken at that time? _____
5. What did you like the most about any former dentist? _____
6. What did you like the least? _____
7. Have you experienced any discomfort from your teeth or gums lately? _____
8. Has the fear of pain kept you from regular dental visits? _____
9. Are you troubled by bad breath? _____
10. Do your gums bleed easily, feel tender or irritated? _____
11. Are your teeth sensitive to hot, cold, or sweets? _____
12. Would you like to retain your natural teeth as long as possible? _____
13. Are you aware of grinding or clenching your teeth? _____
14. Are you interested in cosmetic fillings in place of dark fillings? _____
15. If there was a simple, inexpensive way to whiten your teeth, would you be interested? _____
16. If you could wave a magic wand and change one thing about your smile, what would it be? _____
17. What do you expect of us as your dentist? _____
18. What could we do to make your dental visits more pleasant?
