**EXAMINATION QUESTIONAIRE**

In order for us to give you an accurate diagnosis and the best treatment possible, please take a few minutes to answer the following questions. Thank you!

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_

How long has it been since you've had any of the following?

Dental exam \_\_\_\_\_\_\_\_\_\_ Dental x-rays \_\_\_\_\_\_\_\_\_\_ Professional cleaning \_\_\_\_\_\_\_\_\_\_

What prompted you to seek dental care at this time? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you satisfied with your past dental experiences? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had your wisdom teeth removed? \_\_\_\_\_ Have you worn braces in the past? \_\_\_\_\_\_

Do you wear an appliance (retainer/night guard/snore guard/CPAP)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How often do you usually perform the following?

Brush \_\_\_\_\_\_\_\_\_\_ Floss \_\_\_\_\_\_\_\_\_\_ Professional cleaning \_\_\_\_\_\_\_\_\_\_

Please circle any of the following that pertain to you:

|  |  |  |  |
| --- | --- | --- | --- |
| Bleeding gums | Crooked teeth | Hot/Cold sensitivity | Snoring |
| Chewing sensitivity | Discoloration | Joint discomfort | Tender gums |
| Clenching/grinding | Fatigue | Poor sleep | Throbbing pain |
| Congestion | Frequent headaches | Seasonal allergies |  |

If you circled any of the above items, please explain. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is there anything you would like to change about the appearance of your smile? \_\_\_\_\_\_\_\_\_\_\_

If so, please explain. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

On a scale of 1-10, 10 being very important, how important are your teeth? \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Whom may we thank for your referral? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_