DENTAL HEALTH QUESTIONNAIRE

Today's Date: _____ Printed Name: * _____

What is the reason for today's visit? _____

Date of Last Visit: ☐ 0-6 months ☐ 6 months - 1 year ☐ 1-2 years ☐ 2-3 years ☐ 3-4 years ☐ 4-5 years ☐ > 5 years

How often do you brush your teeth? ☐ > 3x/day ☐ 3x/day ☐ 2x/day ☐ 1x/day ☐ Sometimes ☐ Never

How often do you floss your teeth? ☐ > 2x/day ☐ 2x/day ☐ 1x/day ☐ Sometimes ☐ Never

What type of toothbrush do you use? ☐ Manual ☐ Sonicare ☐ Oral-B ☐ Other Electric

Are any of your teeth sensitive to:			**Have you ever experienced:**		
Hot or Cold?	Y	N	Clicking or popping of the jaw?	Y	N
Sweets?	Y	N	Difficulty opening or closing the mouth?	Y	N
Biting or Pressure?	Y	N	Frequent headaches, neck aches, or shoulder aches?	Y	N
Do your gums bleed or hurt?	Y	N	**Have you ever had:**		
Have you ever noticed any mouth odors or bad taste?	Y	N	Orthodontic treatment?	Y	N
Have your parents experienced gum disease or tooth loss?	Y	N	Oral Surgery?	Y	N
Have you noticed any loose teeth or change in your bite?	Y	N	Teeth Removed?	Y	N
Does food tend to become caught between your teeth?	Y	N	Periodontal treatment?	Y	N
Do you:			Your bite adjusted?	Y	N
Clench or grind your teeth while awake or asleep?	Y	N	A serious injury to the mouth or head?	Y	N
Have tired jaws, especially in the morning?	Y	N			
Bite your lips, cheeks, or tongue regularly?	Y	N	Do you like the appearance of your teeth; your smile?	Y	N
Hold foreign objects with your teeth? (pencils, fingernails, etc.)	Y	N	Do you like the color of your teeth?	Y	N
Mouth breathe while asleep or awake?	Y	N	Are your teeth as straight as you would like?	Y	N
Snore?	Y	N			
Frequently get cold sores, blisters or any lesions?	Y	N	Do you feel anxiety about having dental treatment?	Y	N

I consent to the doctor's exam and necessary diagnostics for treatment including x-rays.

Signature of Patient / Parent / Guardian: Signature of Doctor / Staff:

Welcome and thank you for letting us care for your smile!

COVE
ChoiceDental

When quality and comfort matter, the CHOICE is simple.