Dental Questionnaire

* What is the Date of your last Dental visit? _______________

* What was the nature of this visit? _______________________

* Do you use Mechanical Toothbrush **or** Conventional Manual?

* Do you use Dental Floss? Yes No
* How often? _________________

* Do you, or have you been told, that you clinch or grind your teeth? Yes No

* Do you wake up with or get stress/tension headaches? Yes No

* Do you smoke cigars or cigarettes? Yes No

☺ Are you interested in a whiter smile? Yes No

☺ Would you like straighter teeth? Yes No

☺ Do you have spaces between your teeth that you would like closed? Yes No

☺ Do you have missing teeth that you would like replaced? Yes No

☺ Do you have old silver fillings that you would like to replace
With natural tooth-colored fillings? Yes No

☺ If you could change anything about your smile, what would you change?

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☺ Do you have any other specific concerns that you would like addressed?

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*Are you fearful of dental treatment? Yes No

* What causes your fear? ____

* Is there anything we should know to help make your visit more pleasant?

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