# NEW PATIENT DENTAL HISTORY QUESTIONNAIRE

NAME:_____

1. How did you hear about our office? _____
2. When was your last dental visit? _____
3. When did you last have dental x-rays? _____
4. How often do you brush your teeth? _____
5. How often do you floss your teeth? _____

| | Yes | Unsure | No |
|---|---|---|---|
| 6. Have you been seeing a dentist regularly? | ❑ | ❑ | ❑ |
| 7. Do any of your teeth ache? | ❑ | ❑ | ❑ |
| 8. Do your gums bleed when you brush? | ❑ | ❑ | ❑ |
| 9. Do you have any pain when you brush? | ❑ | ❑ | ❑ |
| 10. Do you feel that you have bad breath? | ❑ | ❑ | ❑ |
| 11. Have you ever been in a vehicle accident or experienced any blows to your jaw? | ❑ | ❑ | ❑ |
| 12. Have you ever had any implant surgery in one or both or your jaw joints? | ❑ | ❑ | ❑ |

If "Yes", who performed the surgery and when was it done: _____

_____

| | | | |
|---|---|---|---|
| 13. Are you being followed-up by a dental specialist? | ❑ | ❑ | ❑ |

If "Yes" , please give name _____

14. Please list anything else not mentioned above regarding your past dental history _____

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