PATEL & DORNHECKER
DENTISTRY

QUESTIONNAIRE

Patient Name:_____ Date:_____

Name of your Physician:_____ Phone:_____

Name of your last Dentist:_____ Phone:_____

Preferred Pharmacy:_____ Phone:_____

Date of last cleaning and examination:_____

Do you have dental anxiety?.....Y / N

Would you like straighter teeth?…….……..……Y / N

Would you like whiter teeth?.....Y / N

Do you have sensitive teeth?.....Y / N

Do you feel like you have bad breath or a bad taste in your mouth?.....Y / N

Do your gums bleed when you brush or floss?.....Y / N

Do you have jaw pain?.....Y / N

Do you have headaches often?.....Y / N

Have you been told you need antibiotics prior to dental visits?.....Y / N

Do you snore?.....Y / N

Do you wear a sleep apnea oral device/C-Pap/Snore Guard?.....Y / N

Have you had a sleep study?.....Y / N

Have you had any dental or facial trauma?.....Y / N

If yes, please explain_____

_____

Have you had your wisdom teeth extracted?.....Y / N

Do you have any other missing teeth?.....Y / N

Do you wear a removable denture or partial?.....Y / N

What is the purpose of you dental visit?_____

Is there anything more you would like to share about yourself?.....Y / N

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FOR OFFICE USE ONLY:

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