auroradentalcentre

Dental Questionnaire

visit our video website at auroradentalcentre.com

Previous Dental History

What is your previous dentist name and phone number?

Name: ____________________ Phone Number: ____________________

When was the last time you visited a dentist or hygienist? Any x-rays?

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How often did you see your last dentist/hygienist?

____

Have you been advised to take antibiotics before dental treatment? ☐ *Yes* ☐ *No* ☐ *Not sure / Maybe*

Is there any history of trauma to your head and/or teeth? ☐ *Yes* ☐ *No* ☐ *Not sure / Maybe*

Current Conditions

Do you have any dental concerns? Any pain or sensitivity in your mouth?

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Do your gums bleed or hurt? Any sore spots? ☐ *Yes* ☐ *No* ☐ *Not sure / Maybe*

Do you feel that you have bad breath on a regular basis? ☐ *Yes* ☐ *No* ☐ *Not sure / Maybe*

Does food get caught between your teeth? Any specific area? ☐ *Yes* ☐ *No* ☐ *Not sure / Maybe*

____

Do you have any missing teeth? Are you considering any replacement?

____

Dental habits

Do you ever have any pain in your jaw, ear or side of your face? ☐ *Yes* ☐ *No* ☐ *Not sure / Maybe*

Do you clench or grind at night? ☐ *Yes* ☐ *No* ☐ *Not sure / Maybe*

Have you ever worn any appliances (ie. a nightguard, retainer) in your mouth? ☐ *Yes* ☐ *No* ☐ *Not sure / Maybe*

What do you use to clean your teeth (ie. electric/manual toothbrush, floss, waterfloss) and how often?

____

Signature: ______________________________ *Date:* ____________________

Patient or Parent / Guardian