

SANCHEZ DENTAL ASSOCIATES

Last

First

Middle

Nickname

Correct answers to the following questions will allow your dentist to treat you on a more individual basis, providing the care appropriate for your particular needs. Your answers are for our records only and will be considered confidential.

1. Are you having any discomfort at this time? _____ Yes _____ No
2. Have you ever had any serious trouble associated with previous dentistry? _____ Yes _____ No
3. Does dental treatment make you nervous? _____ Yes _____ No
4. Date of last dental visit? _____
5. Have you ever been treated for periodontal disease (gum disease, pyorrhea, trench mouth)? _____ Yes _____ No
6. How often do you brush? _____ Brush is: _____ Soft _____ Medium _____ Hard
7. Do you use the following? Brush _____ Yes _____ No / Dental Floss _____ Yes _____ No
Fluoride Rinse _____ Yes _____ No / Other Aids _____ Yes _____ No
8. Do you use an electric toothbrush? _____ If yes, what kind/brand? _____

9. Do you have or have you ever had any of the following?

Mouth

- | | | |
|-----------------------------------|-----------|----------|
| Bleeding, sore gums | _____ Yes | _____ No |
| Unpleasant taste/bad breath | _____ Yes | _____ No |
| Burning tongue/lips | _____ Yes | _____ No |
| Frequent blister, lips/mouth | _____ Yes | _____ No |
| Swelling/lumps in mouth | _____ Yes | _____ No |
| Ortho treatments (braces) | _____ Yes | _____ No |
| Biting cheeks/lips | _____ Yes | _____ No |
| Clicking/popping jaw | _____ Yes | _____ No |
| Difficulty opening or closing jaw | _____ Yes | _____ No |

Teeth

- | | | |
|---------------------|-----------|----------|
| Loose teeth | _____ Yes | _____ No |
| Sensitive to Hot | _____ Yes | _____ No |
| Sensitive to Cold | _____ Yes | _____ No |
| Sensitive to sweets | _____ Yes | _____ No |
| Sensitive to biting | _____ Yes | _____ No |
| Food impaction | _____ Yes | _____ No |
| Clenching/grinding | _____ Yes | _____ No |
| If so, when | _____ | |
| Shifting in bite | _____ Yes | _____ No |

10. These are the things that are important to me about my dental health: _____

11. What do you fear most about dental care? _____

12. Circle One:

- | | |
|--|--|
| <p>A. My mouth is</p> <p>a) very comfortable</p> <p>b) moderately comfortable</p> <p>c) uncomfortable</p> <p>B. I</p> <p>a) think the appearance of my mouth is excellent</p> <p>b) am satisfied with the appearance of my mouth</p> <p>c) am dissatisfied with the appearance of my mouth</p> <p>C. I</p> <p>a) will do anything to keep my natural teeth</p> <p>b) want to keep my teeth, but have a certain budget of time and money that I am willing to spend on them</p> <p>D. I</p> <p>a) I have set goals for my oral health with a previous dentist</p> <p>b) want to set goals concerning my dental health</p> | <p>E. I a) have always done the best that was recommended for my dental health</p> <p>b) have not done what dentists have recommended to me</p> <p>c) rarely go, and don't care much about having any dental work completed</p> <p>F. I a) have put dentistry for myself and family high on my priority list</p> <p>b) put dentistry for myself and my family low on my priority list</p> <p>c) put dentistry is on my list but it's hard to find time</p> <p>G. I think my present state of dental health is:</p> <p>a) Excellent</p> <p>b) Good</p> <p>c) Poor</p> |
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13. What are some questions about dentistry and oral health that you have never had adequately answered? _____

DENTAL QUESTIONNAIRE