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Dental Questionnaire

PLEASE ANSWER ALL OF THE FOLLOWING CONFIDENTIAL QUESTIONS COMPLETELY.

1. Please describe the primary reasons for your visit (concerns):_____
   _____
2. Have you come to this office for pain relief? ☐ Yes ☐ No
   If yes, how long has it hurt?_____
   Where is the pain? _____
   How does it hurt? With: Hot ☐ Yes ☐ No Sweets ☐ Yes ☐ No
   Cold ☐ Yes ☐ No Constantly ☐ Yes ☐ No
3. How long since you have been to a dentist? _____ Month(s) _____ Year(s)
4. When was the last set of full mouth x-rays? _____
5. How often do you brush your teeth? _____
6. Please check any items below that you use often in oral care:

Hand Toothbrush	☐ Yes	☐ No	Gum Stimulators	☐ Yes	☐ No
Electric Toothbrush	☐ Yes	☐ No	Rubber Tips	☐ Yes	☐ No
Dental Floss	☐ Yes	☐ No	Water Spray	☐ Yes	☐ No

7. Have you ever suffered from, or been told you may have any of the following:

Gum Disease	☐ Yes	☐ No	Malocclusion	☐ Yes	☐ No
Bruxism or Grinding	☐ Yes	☐ No	Bad Breath	☐ Yes	☐ No
Jaw Pain or TMJ	☐ Yes	☐ No	Headaches or Migraines	☐ Yes	☐ No
Dental Pain	☐ Yes	☐ No	Extraction complication	☐ Yes	☐ No

8. If you could rate your smile from 1 - 10, what would it be? _____
9. Would you like to improve your smile? ☐ Yes ☐ No How? _____

IF THIS IS FOR A NEW DENTURE, COMPLETE THE FOLLOWING PORTION:

10. When were your natural teeth removed? _____
11. How many sets of dentures have you had? _____
12. When were your present dentures constructed? _____
13. Do you like the appearance of your present set of dentures? ☐ Yes ☐ No
14. Has your present set of dentures ever been relined or rebased? ☐ Yes ☐ No

IF PATIENT IS CHILD, PLEASE ANSWER THE FOLLOWING QUESTIONS:

15. Please check any of the following habits the child has:

Thumbsucking	☐ Yes	☐ No	Nail Biting	☐ Yes	☐ No
Mouth Breathing	☐ Yes	☐ No	Unusual Speech Patterns	☐ Yes	☐ No

CONSENT & ACKNOWLEDGEMENT

***To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in my medical status.**

*** Further, I hereby authorize Tereza Hambarchian, D.D.S. or the designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate to make a thorough diagnosis of my dental needs.**

*** Upon such diagnosis, I authorize Tereza Hambarchian, D.D.S. to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.**

*** I consent to the use of appropriate medication and therapy as deemed necessary. I fully understand that using anesthetic agents embodies a certain risk.**

PATIENT'S NAME: _____ Date: _____

SIGNATURE OF PATIENT, PARENT, OR GUARDIAN: _____

DENTIST'S SIGNATURE: _____ Date: _____