ben pyatt dental

Dental Health Questionnaire

Name: _____ Date: _____

Reason for Visit: _____
When was your last Dental Visit: _____
What were you seen for? _____
Previous Dentist (Name and Location):_____
Did you have X-Rays taken at your last visit? Yes No
If yes, when where the X-Rays taken (Month and Year)? _____
Were you referred to our office? Yes No If yes, by who? _____

Are your teeth sensitive to: Hot/Cold Biting/Chewing Sweets None Other:_____
Have you ever had Orthodontic Treatment? Yes No
Do you, or have you ever, had a Night Guard? Yes No
Have you ever had Periodontics Treatment? Yes No If yes, when (year)? _____

How often do you brush? _____
How often do you floss? _____
Do you use mouthwash (What kind)? _____

Do you do any of the following? (Please Circle All that Apply)

Grind Teeth	Bite Nails
Clinch Teeth	Eat Candy
Bite Cheek	Soft Drinks
Tongue Thrust	Coffee
Mouth Breather	Electric Toothbrush
Smoke	Smokeless Tobacco

Do you like your smile? Yes No
If no, would you be interested in letting us help you love your smile? Yes No
Would you be interested in Teeth Whitening? Yes No