ProDent Care
Modern Dentistry with a Caring Touch

Dental Questionnaire

Print Form

PLEASE ANSWER ALL OF THE FOLLOWING CONFIDENTIAL QUESTIONS COMPLETELY.

1. Please describe the primary reasons for your visit (concerns):
   1. _____
   2. _____
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 Tooth Brush	☐ Yes ☐ No	Gum Stimulators	☐ Yes ☐ No
Electric Tooth Brush	☐ 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	Nailbiting	☐ Yes ☐ No
Mouthbreathing	☐ 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: _____

© 2008 ProDent Care, Dental Practice of Tereza Hambarchian, D.D.S., Inc. -- All Rights Reserved.