BRIGHAM DENTAL CARE

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SUPPLEMENTAL DENTAL QUESTIONNAIRE FOR NEW PATIENTS

First Name *Middle* *Last* *Preferred Name*

Please answer the following questions accurately to permit your dentist to treat you appropriately based on your particular needs. Your answers will be considered confidential and are for your records only.

1. How often do you brush? ____________________

   Type of brush: soft_____ medium_____ hard_____ electric/automatic toothbrush_____

2. How often do you floss? ____________________
3. What was done at your last dental visit?

   ____

4. Have you ever been treated for periodontal / gum disease? Y N When? _____________________
5. Do you use fluoride rinse or supplement? Y N

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

YES	NO	IN PAST	
________	________	________	Bleeding, sore gums
________	________	________	Swelling, lumps in mouth
________	________	________	Orthodontic treatment (braces) When? _______________________
________	________	________	Clicking / popping jaw
________	________	________	Change in bite / the way your teeth come together
________	________	________	Difficulty in opening or closing mouth
________	________	________	Loose teeth
________	________	________	Sensitivity to hot
________	________	________	Sensitivity to cold
________	________	________	Sensitivity to sweets
________	________	________	Sensitivity to biting
________	________	________	Food packing between teeth
________	________	________	Broken teeth
________	________	________	Broken fillings
________	________	________	Wisdom teeth removed
________	________	________	Partial denture
________	________	________	Full denture
________	________	________	Clenching and / or grinding of teeth
________	________	________	Traumatic injury to the mouth or jaw

Is there anything else we should know about you?

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Satisfaction Level

Please check the appropriate boxes:

1. My mouth is . . .
   - ❑ Very comfortable
   - ❑ Moderately comfortable
   - ❑ Moderately uncomfortable
   - ❑ Very uncomfortable
2. I . . .
   - ❑ Am satisfied with the appearance of my teeth.
   - ❑ Am dissatisfied with the appearance of my teeth.
3. I . . .
   - ❑ Will do anything to keep my natural teeth.
   - ❑ Want to keep my teeth, but have a certain budget of time that I am willing to spend.
   - ❑ Want to keep my teeth, but have a certain budget of money that I am willing to spend.
4. I . . .
   - ❑ Have set goals for my oral health with a previous dentist.
   - ❑ Want to set goals concerning my dental health.
5. I . . .
   - ❑ Have always done the best that was recommended for my dental health.
   - ❑ Have not done what dentists have recommended to me.
   - ❑ Rarely go to the dentist, and not very interested in dental work.
6. I . . .
   - ❑ Have put dentistry for myself high on my priority list.
   - ❑ Have put dentistry for myself low on my priority list.
7. I . . .
   - ❑ Have put dentistry for my family high on my priority list.
   - ❑ Have put dentistry for my family low on my priority list.
8. I . . .
   - ❑ Look forward to my dental visits.
   - ❑ Feel indifferent about dental visits.
   - ❑ Have some anxiety about dental visits.
   - ❑ Dread dental visits and feel very nervous.

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

____

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____

2. What I expect from my dentist:

____

____

____

3. What are some questions about dentistry and oral health that you have never had adequately answered?

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