DEVON DENTAL ASSOCIATES
ORAL AND DENTAL HEALTH QUESTIONAIRE

1. Chief Dental Concern _____
2. When was your last dental visit? _____ For what purpose? _____
3. How frequently in the past have you had routine dental examinations? _____
4. Brushing frequency ( ) times per day Flossing frequency ( ) times per week
5. Have you ever been shown the proper way to brush and floss your teeth? ..... ☐ Yes ☐ No

HAVE YOU PREVIOUSLY HAD ANY OF THE FOLLOWING?: (check all that apply)

- ☐ Orthodontics(Braces)
- ☐ Wisdom Teeth Removed
- ☐ Periodontal (Gum) Treatment
- ☐ Nightguard or Retainer Appliance
- ☐ Removable Partial Denture(s)
- ☐ Trauma to a tooth (teeth)
- ☐ Trauma to the Jaw(s)

ARE ANY OF THE FOLLOWING CURRENT PROBLEMS FOR YOU?: (check all that apply)

- ☐ Tooth Cold Sensitivity
- ☐ Tooth Hot Sensitivity
- ☐ Tooth Sweet Sensitivity
- ☐ Tooth Chewing Discomfort
- ☐ Toothaches
- ☐ Loose Teeth
- ☐ Shifting Teeth
- ☐ Rough Or Broken Fillings
- ☐ "Food Traps" Between Teeth
- ☐ Bleeding Gums
- ☐ Swollen Gums
- ☐ Bad Breath Or Bad Taste
- ☐ Tooth Clenching Or Grinding During Day Or Night
- ☐ Tooth Wear Or Abrasion
- ☐ Frequent Headaches
- ☐ Jaw Joint Locking, Sticking, Or "Going Out"
- ☐ Jaw Joint "Clicking, Popping, Or Grating" Noises
- ☐ Jaw Joint, Face, Or Chewing Muscle Pain Or Tightness
- ☐ Snoring

6. Are you happy with the appearance of your teeth? ☐ Yes ☐ No

WHICH COSMETIC TOOTH CHANGES WOULD YOU BE INTERESTED IN DISCUSSING? (check all that apply)

- ☐ Improving Tooth Color
- ☐ AlteringTooth Shape
- ☐ Correcting Tooth Size
- ☐ Enhancing Teeth Brightness
- ☐ Correcting Teeth Spacing
- ☐ Correcting Teeth Crowding
- ☐ Replacing Missing Teeth
- ☐ Teeth Whitening (Bleaching)
- ☐ Replacing Unesthetic Crown(s) (i.e., "Caps")
- ☐ Replacing Silver (Black) Fillings With Tooth Colored Fillings

7. How important is it that you keep your remaining natural teeth for life?
   ☐ Very Important ☐ Not too Important ☐ Not Important at all
8. Have you been satisfied with the dental care you have received in the past? ☐ Yes ☐ No
   If No, Why? _____
9. Name and address of previous Dentist: _____

PATIENT SIGNATURE _____

DOCTOR'S NOTES

DATE / /

DOCTOR SIGNATURE _____