Dental Information Questionnaire Date_____

_____

Last Name First Name Middle Name Preferred Name

Correct answers to the following questions will allow Dr. Holland to treat you on a more individualized basis, providing the care appropriate for your particular needs and desires. Your answers are for our records only and will be considered confidential.

Dental History

1. Referred by _____
2. Previous dentist _____
3. How long have you been a patient? _____Month/Years
4. Date of most recent dental exam _____
5. Most recent x-rays _____
6. Date of most recent treatment (other than cleanings) _____
7. I routinely see my dentist every: 3 months 4 months 6 months 12 months Not routinely
8. How would you rate your present state of dental health?
   Excellent Good Fair Poor
9. How often do you: Brush _____ Floss _____ Other _____
10. Are you experiencing any discomfort currently? _____
11. What is your immediate concern? _____
    _____
12. Is there anything that would stand in the way of getting the proper dental care that you need? __
    _____
    _____

Personal History

1. Does dental treatment make you anxious or fearful? _____
2. Have you ever had an unpleasant dental experience? _____
3. Have you ever had complications from past dental treatment? _____
4. Have you ever had trouble getting numb or a reaction to local anesthesia? _____
5. Have you ever had braces, orthodontic treatment, or your bite adjusted? _____
6. Have you had any teeth removed? _____
7. Do you have any missing teeth that have not been replaced? _____

Smile Characteristics

1. If you could change anything about the appearance of your teeth, what would it be?
   _____
2. Have you ever whitened or bleached your teeth? _____
3. Are you self-conscious about your teeth? _____ If yes why? _____
   _____
4. Have you been disappointed by the appearance of any previous dental work? _____

Bite and Jaw Joint

1. Do you/would you have any problems chewing gum? _____
2. Do you/would you have any problems chewing bagels or other hard foods? _____
3. Have your teeth changed in the last five years? _____ Become: Shorter Thinner Worn
4. Are your teeth crowding or developing spaces? _____
5. Have you ever been told you grind your teeth? _____
6. Do you have more than one bite (squeeze to make teeth fit together) _____
7. Do you clench (squeeze to make teeth fit together)_____
8. Do you have problems with sleep, or wake up with an awareness of your teeth? _____
9. Do you have problems with your jaw joint? Pain Sounds Limited opening Locking Popping
10. Do you have tension headaches or sore teeth? _____
11. Do you or have you ever worn a bite appliance? _____

Tooth structure

1. Have you had any cavities within the last three years? _____
2. Do you have a dry mouth? _____
3. Have you ever had any of the following:
   Toothache cracked filling broken tooth chipped or cracked tooth
4. Do you avoid brushing any part of your mouth?_____

Gum and Bone

1. Have you ever been diagnosed with periodontal disease (Gum disease)?
   _____
2. Have you ever been treated for the above condition? If so, when? _____
   _____
3. Is there anyone in your family with a history of periodontal disease? _____
4. Do your gums bleed when you brush, floss, or eat? _____
5. Are your teeth becoming loose? _____
6. Have you ever noticed an unpleasant taste or odor in your mouth? _____
7. Have you experienced a burning sensation in your mouth? _____

Tell us about yourself

We like to get to know our patients! Tell us a little about yourself: Hobbies, family, work, etc!

_____
_____
_____
_____
_____
_____
_____