West River Dental Questionnaire

Name: _____ Date: _____

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

1. Are you having any discomfort at this time? Yes ☐ No ☐
2. Reason for coming in today? _____
3. Is your visit due to an injury? Yes ☐ No ☐ Date of Injury: _____

   What Happened? _____
4. Have you ever had any serious trouble associated with previous dentistry? Yes ☐ No ☐
5. Does Dental Treatment make you nervous? No ☐ Slightly ☐ Moderately ☐ Extremely ☐
6. Date of Last Visit, if at another office? _____/_____/_____
7. Have you ever been treated for periodontal disease? Yes ☐ No ☐
8. 8. Do you ever have or have you ever had any of the following?

MOUTH		TEETH	
Bleeding or sore gums	☐ Yes ☐ No	Loose Teeth	☐ Yes ☐ No
Unpleasant taste/bad breath	☐ Yes ☐ No	Sensitive to Hot	☐ Yes ☐ No
Burning tongue/lips	☐ Yes ☐ No	Sensitive to Cold	☐ Yes ☐ No
Frequent blister, lip/mouth	☐ Yes ☐ No	Sensitive to Sweets	☐ Yes ☐ No
Swelling/lumps in mouth	☐ Yes ☐ No	Sensitive to Biting	☐ Yes ☐ No
Ortho Treatments (braces)	☐ Yes ☐ No	Food Impaction	☐ Yes ☐ No
Biting Cheeks/lips	☐ Yes ☐ No	Clenching/grinding	☐ Yes ☐ No
Clicking/popping jaw	☐ Yes ☐ No	Shifting in Bite	☐ Yes ☐ No
Difficulty opening or closing jaw	☐ Yes ☐ No	Change in Bite	☐ Yes ☐ No

Do you use the following?

Toothbrush	☐ Yes ☐ No	Dental Floss	☐ Yes ☐ No
Fluoride Rinse	☐ Yes ☐ No	Waterpik	☐ Yes ☐ No

SMILE GUIDE

Do you like... your smile?	☐ Yes ☐ No
The color of your teeth?	☐ Yes ☐ No
Position/Orthodontics?	☐ Yes ☐ No
Shape of Teeth?	☐ Yes ☐ No

Rank your smile from: 1 2 3 4 5 6 7 8 9 10

1=Unhappy 10=Very Happy

If not 10, what can we do to make it a 10?

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