TIFFIN FAMILY DENTISTRY

Good Is Not Enough ~ Excellence is a Must

Dental Health Questionnaire

Please answer the following questions correctly to allow your dentist to be able to treat you on a more individual basis and provide the care appropriate for your particular needs.

1. Are you having any discomfort at this time?

☐ Yes ☐ No

2. Date of your last dental visit? _____

3. Have you been treated for any type of gum problems?

☐ Yes ☐ No If yes what treatment did you have: _____

4. Are you happy with the appearance of your smile? (Ex: Straighter teeth, whiter teeth)

☐ Yes ☐ No If no, what would you change? _____

_____

5. Do you have or have you ever had, any of the following conditions?

Mouth Problems	☐ Yes	☐ No	Teeth Problems	☐ Yes	☐ No
Bleeding/Sore gums	☐ Yes	☐ No	Loose Teeth	☐ Yes	☐ No
Unpleasant/bad breath	☐ Yes	☐ No	Sensitivity to hot/cold	☐ Yes	☐ No
Burning tongue/lips	☐ Yes	☐ No	Sensitivity to sweets	☐ Yes	☐ No
Ortho treatment (braces)	☐ Yes	☐ No	Sensitivity to biting	☐ Yes	☐ No
Swelling in the mouth	☐ Yes	☐ No	Food Stuck in teeth	☐ Yes	☐ No
Clicking/popping jaw	☐ Yes	☐ No	Clenching/grinding	☐ Yes	☐ No

6. How would you rate your dental health? ☐ Excellent ☐ Good ☐ Poor

What is important to you about your dental health?

_____

_____

_____

We are excited to meet you and help you achieve your Life Smile!