Houston (713) 347-6833
Dallas (214) 550-7323

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(713) 347-6844

DENTAL QUESTIONNAIRE

Patient Name: ______________________ ___ ______________________ ______________ ____________
First M.I. Last Nickname DOB

WHAT IS THE PRIMARY REASON FOR CONTACTING THE DENTIST? (Please be as detailed as possible)

DENTAL QUESTIONS	DENTAL ANSWERS (Please choose only the most accurate answer)					
When was the patient last seen by a dentist?	☐	Within last 6 Months	☐	Within last 12 Months	☐	More than 12 Months ago
How often does the patient brush their teeth?	☐	Multiple times/day	☐	Once per day	☐	Less than daily
Is the patient having difficulty eating/biting food?	☐	Yes	☐	No	☐	Occasionally
Do the patient's gums bleed?	☐	Yes	☐	No	☐	Occasionally
Does the patient have bad breath?	☐	All of the time	☐	Some of the time	☐	Never
Does the patient use a mouthwash or rinse?	☐	All of the time	☐	Some of the time	☐	Never
Is the patient cooperative during dental treatment?	☐	Yes	☐	No	☐	Occasionally
Does the patient have dentures?	☐	Yes	☐	No		
Does the patient have a crown or crowns?	☐	Yes	☐	No		
Does the patient have an implant or implants?	☐	Yes	☐	No		
Has the patient ever had a reaction to anesthetic?	☐	Yes	☐	No		

SIGNATURE ACKNOWLEDGEMENT

To the best of my knowledge, I have provided the most accurate patient information related to ______________________________
Print Patient's Full Name
and therefore, release the treating dentist from any responsibility that may arise from any omissions or inaccuracies.

______________________________ ______________________________ ______________
Signature Please Print Signer's Name Date

Signer's Legal Authority? ☐ Patient(self) ☐ Responsible Party ☐ Guardian ☐ Power of Attorney ☐ Conservator ☐ __________

Signer's Relationship To Patient? ☐ Patient(self) ☐ Daughter ☐ Son ☐ Spouse ☐ Mother ☐ Father ☐ __________