Croasdaile DENTAL ARTS
Your Smile. Our Passion.

Adult New Patient
Dental History Questionnaire

Patient Name: _____ **DOB: _____**

What would you like to accomplish today? _____
What prompted you to seek dental care at this time? _____
Have you been asked to take an antibiotic before dental treatment? ☐Yes ☐ No

Please check if you have ever had problems with any of the following:
☐Sensitivity to cold ☐Jaw/ear pain ☐Bleeding Gums ☐Food sticks between teeth
☐Sensitivity to hot ☐Grinding/clenching teeth ☐Periodontal treatment ☐Mouth sores/growths
☐Sensitivity when biting ☐Clicking or popping jaw ☐Loose teeth/broken fillings ☐Bad Breath/Taste
☐Sensitivity to sweets ☐Worn/chipped teeth ☐Dark teeth ☐Hard to floss

Home Care Evaluation
How often do you brush?_____ Toothbrush: ☐ Electric ☐ Regular ☐ Soft ☐ Medium ☐ Hard
How often do you floss?_____ Any other homecare devices that you use? _____
Is it difficult for you to brush or floss any areas of your mouth? ☐ Yes ☐ No
If yes, please describe: _____

Do your gums bleed when brushing or flossing?	☐ Yes ☐ No
Do you have dry mouth?	☐ Yes ☐ No
Do you want to learn to control dental disease & keep your teeth?	☐ Yes ☐ No
Have you ever been instructed in the prevention of decay?	☐ Yes ☐ No
Have you been instructed in caring for the health or your gums?	☐ Yes ☐ No
Do you feel like keeping your teeth healthy has been a losing battle?	☐ Yes ☐ No

If yes, why? _____

Do you have any concerns about getting your mouth in excellent health?	☐ Yes ☐ No

If yes, what concerns you?_____

Do you snack between meals on sweets, gum or soda pop?	☐ Yes ☐ No
Do you chew on both sides of your mouth?	☐ Yes ☐ No ☐ Unsure

Smile Evaluation
What do you like about your smile? _____
What don't you like about your smile? _____

Do you sometimes hesitate to smile?	☐ Yes ☐ No
Are your teeth white enough?	☐ Yes ☐ No
Are there old fillings or dental work that look bad to you?	☐ Yes ☐ No
Do you like the shape of your teeth?	☐ Yes ☐ No
Are your teeth straight enough?	☐ Yes ☐ No
Do you have spaces between your teeth that you don't like?	☐ Yes ☐ No
Has cost prevented you from enhancing your smile in the past?	☐ Yes ☐ No

Other History

Are you anxious about receiving dental treatment?	☐ Yes ☐ No

If yes, what do you dislike? _____

Has fear of discomfort kept you from regular dental visits in the past?	☐ Yes ☐ No

What else would you like us to know about your past dental experiences?
_____

Have you ever had a reaction to a dental product or procedure?	☐ Yes ☐ No

If yes, please describe: _____
Previous Dentist: _____ Address _____ City _____, State _____
Date of Last visit: _____ Date of Last X-rays: _____

SIGNATURE:_____ **DATE:_____**
CDA-DH revised 7/27/17