Lincoln Village Dental *Dental History Questionnaire*

Patient Information

First Name ____________________ Middle Name __________ Last Name _________________________

Preferred Name _____________________ Reason for Today's Visit _______________________________

Former Dentist ______________________________________ Phone ( ) _______________________

What did you like *best* about your former dental office? ____

Is there anything you didn't like about your former dental office? __________________________________

When was your last dental visit, and what did you have completed? _________________________________

In case of an emergency, please contact:

Name ________________________ Relationship ___________ Phone ( ) _______________________

Please check if you have had difficulty with any of the following:

❑ Bleeding Gums	❑ Chronic Bad Breath	❑ Loose Teeth
❑ Difficulty Chewing	❑ Injury to Front Teeth	❑ Grinding of Teeth
❑ Decayed Teeth	❑ Sensitivity to Sweets or Biting	❑ Pain in Jaw/Locking Jaw
❑ Swelling in Jaw	❑ Sensitivity to Hot/Cold	❑ Food Catches Between Teeth

Do you feel anxious about coming to the dentist? ❑ Yes ❑ No

Do you avoid seeking regular dental care? ❑ Yes ❑ No

Do you want to keep your teeth for a lifetime? ❑ Yes ❑ No

Do you feel that you understand your dental health needs well? ❑ Yes ❑ No

Are you interested in knowing about the latest dental technology? ❑ Yes ❑ No

Have you ever thought about whitening your teeth? ❑ Yes ❑ No

Have you been instructed regarding proper home care? ❑ Yes ❑ No

Do you frequently snack between meals on sweets or chew gum? ❑ Yes ❑ No

How often do you brush your teeth? ____

Are you dissatisfied with the appearance of your teeth in any way? ❑ Yes ❑ No

If so, what would you like to change? ____________________________________

Are you interested in straightening your teeth? ____________________________________

What prompted you to seek dental care at this time? _______________________________

Do you get frustrated because you always have something to be treated or repaired? ❑ Yes ❑ No

Have you ever had any teeth removed? ❑ Yes ❑ No

If so, how long have they been missing? __________________________________

Do you wear a partial or complete denture? ❑ Yes ❑ No

Are you deeply concerned about the finances required to maintain excellent oral health? ❑ Yes ❑ No

Signature of Patient ____ Date __________

(Or Guardian if under 18 years of age)