Dental Questionnaire

1.	Do you prefer to save your teeth for your lifetime? **If no**, why not? ______________________	(yes)	(no)
2.	Do you think your dental health affects your overall physical health?	(yes)	(no)
3.	Are your teeth sensitive, causing pains, or bothering you in any way?	(yes)	(no)
4.	Have you ever had any gum disease problems?	(yes)	(no)
5.	Does tooth loss tend to run in your family?	(yes)	(no)
6.	Have you ever had an oral cancer exam?	(yes)	(no)
7.	Have you ever had a toothache or a fractured tooth?	(yes)	(no)
8.	Do you have areas that are difficult to floss?	(yes)	(no)
9.	Have you noticed any spots or stains on your teeth that concern you?	(yes)	(no)

10. If you could change anything about your smile, which of the following might you change?

☐ Whiter ☐ Close space(s) ☐ Repair chipped teeth
☐ Replace missing teeth ☐ Less gum showing ☐ Replace old crowns

Explain: ____

11. Please rate the following on a scale of 1 to 10 (10 being highest):

a.	How would you rate your overall oral/dental health?	1 2 3 4 5 6 7 8 9 10
	Where would you like it to be?	1 2 3 4 5 6 7 8 9 10
b.	How would you rate the appearance of your smile?	1 2 3 4 5 6 7 8 9 10
	Where would you like it to be?	1 2 3 4 5 6 7 8 9 10

12. Are you looking for: ☐ long-term solutions to problems or ☐ short-term patchwork solutions?

Frederick S. Hecht D.M.D., PC 1520 Richmond Avenue, Staten Island, NY 10314 718-761-5757
www.afraidofthedentist.com