Rosenwald & Associates
Cosmetic, Restorative and Preventive Dentistry

NEW PATIENT QUESTIONNAIRE

NAME _____

Please answer these questions to help us better meet your needs. Thank you!

What are your chief concerns? _____

Are you having any specific problems? _____

Do you have any concerns about your dental health or cosmetics that you would like us to discuss or explore with you? _____

What are your goals for your teeth and smile?

Short term goals? _____

Long term goals? _____

Please circle the answer to the following questions.

Yes No Do you chew well and comfortably?
No Yes Have you ever had a serious injury to your face or jaw joints?
No Yes Do you get pain in your face, muscles, or jaw joints?
No Yes Do your gums bleed?
No Yes Do you have any areas of gum recession?
No Yes Have you had decay or cavities in the last two years?
Yes No Does your drinking water have fluoride in it?
Yes No Do you use a fluoride toothpaste?
No Yes Do you eat frequent snacks?
No Yes Do you eat acidic foods or drink acidic beverages often?
Yes No Do you brush immediately after eating and/or drinking?
No Yes Do you smoke or use any other forms of tobacco? If so, what and how often? _____
No Yes Do you take any medications that inhibit your salivary flow resulting in a dry mouth?
Yes No Do you floss? If so, how many times a day? _____

How often do you brush per day?_____ When? _____

When were your teeth last cleaned? _____ How often do you normally get them cleaned? _____

No Yes Would you like to use Nitrous Oxide during your dental treatment?
No Yes We have radio headsets available for you. Would you like to use them during your dental treatment?

Please tell us how we can best meet your needs _____

_____

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