<u>New Patient Questionnaire</u>

1. Please tell us what brought you to our office today.
   ____
2. What is your primary dental concern.
   ____
3. When was your last cleaning and exam?______________________________
4. When was the last time you had x-rays taken?__________________________
5. Have you ever had orthodontic treatment? ____________________________
6. Have you had your wisdom teeth removed ?___________________________

<u>Do you have any of the following:</u>

_____. Sensitive teeth, hot /cold, sweets
_____. Are any teeth sensitive to pressure or biting
_____. Do your gums bleed
_____. Do you clench or grind your teeth
_____. Do you have any pain in your jaw joint or muscles of the head/or neck

Is there anything in particular you would like us to know about your dental needs?____
____
____

Is there anything in particular we can do to make you visit here comfortable?____
____
____