Kindred Oaks
DENTISTRY

Dental Health Questionnaire

My dental health goals are: (Please circle all that apply to you)

Pain Free	Replacing Missing Teeth	Sedation Dentistry
Whiter Teeth	Full Dentures	Decrease Sensitivity
Straighter Teeth	Cavity Free	Partials
Healthier Gums	Better Breath	Better Chewing
Stop Smoking	Less Bleeding	Other:_____

When was the last time you were seen by a dentist? _____
When was the last time your teeth were cleaned? _____
What type of toothbrush do you use? (circle your choice) Hard Medium Soft Electric
Which over the counter oral rinse(s) are you using? _____

May we take x-rays on you if they are needed?		
Do you take fluoride supplements?		
Have you ever had periodontal (gum treatment)?		
Have you ever had orthodontic treatment (braces)		
Do you floss regularly? (circle your closest frequency) Daily 2-4x/wk 1x/wk Periodically		
Do your gums bleed when you brush and floss?		
Do you consistently get a bad taste in your mouth?		
Have you been sedated for dental treatment?		
I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care		

_____ _____ _____

Patient Name Patient| Parent or Guardian Signature Date