New Patient Dental Questionnaire

When was your last dental examination or dental cleaning?_____

Do you like the appearance of your teeth? Yes ____ No ____

If No, what would you like to change: _____

How do you feel about your current oral health?: _____Good _____Fair _____Poor

How many times do you brush per day? _____ Floss per week? _____

Do you have problems with unpleasant breath? Yes ____ No ____

Do your gums bleed when you brush or floss? Yes ____ No ____

Please rate the following:

Gum Sensitivity:

None				High
1	2	3	4	5

Pain tolerance:

None				High
1	2	3	4	5

Dental anxiety:

None				High
1	2	3	4	5

Is there anything about your smile that concerns you? _____

_____

Please mark any service you would like to further discuss with Dr. Koo:

____Missing Teeth
____Chipped Teeth
____Extractions
____Old Dental Work
____Tooth Decay
____Cosmetic Work (veneers)
____Invisalign/ Clear Correct
____Mouth Guards
____Teeth Grinding/TMJ
____Bite Adjustments
____Gum Disease
____Blisters, Sores, Swelling
____Teeth Whitening (bleaching)

Have you ever had or experienced:

Yes___No___. Orthodontics/Braces?
Yes___No___.Periodontal disease?
Yes___No___. Deep Cleaning?
Yes___No___. Root Canals?
Yes___No___. Oral Surgery?
Yes___No___. Wearing a night guard?
Yes___No___. Implants?
Yes___No___. Injury to the teeth, mouth, or head?
Yes___No___. Crowns?
Yes___No___. Bridge/Partial?
Yes___No___. Dentures?
Yes___No___. Tooth colored filings?
Yes___No___. Gum Contouring?
Yes___No___. Oral Cancer?
Yes___No___. Sedation for treatment?

Dental History Acknowledgement

I understand that the information in the Dental History that I have given is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidence and that you have my permission to ask the respective health care provider or agency for further information if needed. It is my responsibility to inform this office of any changes in my health and medications.

Print Name:_____Relationship to patient:_____
Signature: _____ Date:_____