DR. KIRK MASSNER
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(319) 752-5494

Dental Questionnaire

NAME_____

Correct answers to the following questions will allow is to treat you on a more individual basis, providing the appropriate care for your particular needs. Your answers are for our records only and will be considered confidential.

Are you having discomfort at this time? Yes No

Have you ever had serious trouble with previous dentistry? Yes No

Does dental treatment make you nervous? Yes No

Date of last dental visit? _____

Have you ever been treated for periodontal disease (gum disease)? Yes No

How often do you brush? _____

Is your toothbrush _____soft _____ medium _____ hard?

DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING:

Bleeding or sore gums Yes No

Unpleasant taste or bad breath Yes No

Burning tongue/lips Yes No

Frequent blisters on lips or mouth Yes No

Swelling or lumps in your mouth Yes No

Orthodontic treatment (braces, etc.) Yes No

Biting cheeks or lips Yes No

Clicking or popping jaw Yes No

Difficulty opening or closing jaw Yes No

Loose teeth Yes No

Sensitive to _____ hot _____cold _____ sweets _____ biting

Food impaction Yes No

Clenching or grinding Yes No

Shifting or change in bite Yes No

What is most important to you about your dental health?

_____

My mouth is _____very comfortable, _____moderately comfortable or_____uncomfortable?

I think the appearance of my mouth is _____excellent, _____satisfactory, _____ poor.

I think my present state of dental health is _____excellent, _____ good, _____ poor?

1.) I will do anything to keep my natural teeth, although I have a certain budget of money and time_____
2.) I have set goals concerning my dental care and would like to discuss those goals with my dentist_____
3.) I would like my financial options discussed with me prior to any dental care_____

SIGNED: _____DATE:_____