PACIFIC NORTHWEST SMILES

PROVIDING YOU WITH THE BEST CARE POSSIBLE

Welcome, and thank you for choosing us. Our goal is to help you achieve all the benefits of excellent dental health.

To get started, your answers to the questionnaire below will help us plan the best care possible for you and your family.

Name Date

YOUR DENTAL GOALS

What are your expectations as you enter the care of a new dental practice?

Do you have any particular dental results in mind at present, or in the future?

If you were free to change anything about your smile, what would that be?

Have you ever worked with a dentist on a long-term treatment plan?

DENTAL CARE HISTORY

Growing up, did you visit your dentist regularly? Y N

How long has it been since you visited a dentist?

Who was your previous dentist?

Have you ever felt anxiety about visiting a dentist? If so, why?

As a child, did you need a lot of fillings, or very few?

Do you have bonding, veneers or other cosmetic dentistry?

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DENTAL CARE ISSUES

Please share any thoughts or concerns you may have about the dental care you are seeking from our practice.

EVERYDAY HABITS

Do any of the following apply to you?

Clenching your teeth during the day	Y	N
Grinding your teeth at night	Y	N
Biting your lips or cheeks often	Y	N
Sleeping with your mouth open	Y	N
Chewing tobacco or snuff	Y	N
Smoking cigarettes	Y	N
Chewing foreign objects (pencils, etc.)	Y	N

PERIODONTAL

Have you ever had the following:

Pocket measurements	Y	N
Bone loss evaluation	Y	N
Root planning	Y	N
Mouth odor	Y	N
Loosening teeth	Y	N
Painful, swelling gums	Y	N

JAW PROBLEMS

Have you ever experienced:

Treatment for TMJ	Y	N
Clicking of the joints	Y	N
Difficulty chewing	Y	N
Jaw pain	Y	N
Jaw locking	Y	N
Chronic neck or shoulder pain	Y	N
Morning headaches	Y	N
Chronic headaches	Y	N
Migraine headaches	Y	N

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TELL US ABOUT YOURSELF

We want to learn how to serve you better. Please mark each scale below to match your feelings about the following issues:

My dental care depends on my insurance coverage.	———	I make my own decisions about what's best for me.
I'm fully aware of the state of my present dental health.	———	The present state of my dental health is not clear to me.
I'm interested in cutting-edge dental treatments.	———	I prefer treatments that I have past experience with.
Understanding the details is most important to me.	———	Understanding the big picture is most important to me.
I want long-term solutions, even if they cost more.	———	I prefer temporary solutions because they cost less.
I only want to consider a few of the most basic options.	———	I like to learn about all the options available to consider.
I believe that self-maintenance can prevent most dental problems.	———	I believe that professional care is the best route to good dental health.
I prefer to postpone dental procedures until they can no longer be avoided.	———	I believe it is important to undergo recommended dental care without delay.

PLEASE RANK THE FOLLOWING DENTAL BENEFIT IN ORDER OF IMPORTANCE:

_____ Comfort
_____ Function
_____ Health
_____ Appearance
_____ Precision
_____ Peace of Mind
_____ Durability
_____ Other: _____

REGARDING DECISIONS YOU MAKE ABOUT YOUR FAMILY'S DENTAL HEALTH, PLEASE RANK THE FACTORS BELOW IN ORDER OF IMPORTANCE:

_____ Money
_____ Time
_____ Personal Effort
_____ Physical discomfort
_____ Fear/Anxiety
_____ Other: _____