WEST MOBILE DENTAL CARE

Dental Health Questionnaire

My dental health and treatment 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	Hollywood Smile
Healthier gums	Better breath	Partials
Stop smoking	Less bleeding	Better chewing

Other:_____

When was the last time you were seen by a Dentist? _____

When was the last time your teeth were cleaned? _____

Do you have well or county water? _____

What type of toothbrush do you use? (circle your choice) Hard Medium Soft or Electric

Which over the counter oral rinse(s) are you using? _____

	Yes	No
May we take dental 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 or floss?		
Have you ever been concerned about bad breath?		
Do you consistently get a bad taste in your mouth?		
Are you nervous?		
Have you ever been sedated for dental treatment?		
I consent to the diagnostic procedure and treatment by the dentist necessary for proper dental care.		

Please help us know how you found us by circling one of the following:

Insurance Provider	Radio	Groupon	Vendor Expo
Online Search	Facebook/Twitter	Angie's List	Other_____
Personal Referral	Drive By/Walk-in	Coupon	

_____ _____ _____

Patient Name (Please Print) | Patient \| Parent or Guardian Signature | Date