GETTING TO KNOW YOU

Name:
Date:

The purpose of this questionnaire is

- to highlight any concerns you have about your teeth or gums
- to find out how you feel about the appearance of your smile
- to make us aware of any concerns you may have about your dental treatment

Are you concerned about ? (circle all responses)

Bleeding gums	Y	N
Bad taste / bad breath	Y	N
Teeth sensitivity	Y	N
Worn teeth	Y	N
Teeth which are painful on biting	Y	N
Migraines / headaches / snoring	Y	N

How do you feel about your teeth ? (circle all responses)

Too small or short	Y	N
Too large or long	Y	N
Crooked / crowded / spaced	Y	N
Misshaped (uneven/pointed)	Y	N
Discoloured by old fillings or crowns	Y	N
Not as white or bright as they could be	Y	N

If there is one thing you could change about your smile, what would that be?

How do you feel about visiting the dentist or hygienist ?

I feel relaxed ☐
I feel a little anxious ☐
I feel very anxious and nervous ☐

Are there other dental issues not listed above that you would like to discuss with us?

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