Dr. Vicki L. Tibbs, D.D.S., P.C.

# DENTAL HISTORY & QUESTIONAIRE

When was your last visit to the Dentist?

______________________________________________

What is the nature of your current visit?

______________________________________________

How often do you brush your teeth? ______________________________

Which of the following do you use: ☐ Manual Toothbrush ☐ Electric Toothbrush

Do you use Dental Floss? YES ○ NO ○ If YES, How often? __________

Do you smoke or use tobacco products? YES ○ NO ○

What is the most important thing to you about your future smile and your dental health?

______________________________________________

ON A SCALE OF 1 TO 10 ( 10 BEING THE HIGHEST) **:**

How important is your dental health to you?

1 2 3 4 5 6 7 8 9 10

Where would you rate your current dental health?

1 2 3 4 5 6 7 8 9 10

Where would you like your dental health to be?

1 2 3 4 5 6 7 8 9 10

**HAVE YOU EXPERIENCED ANY OF THE FOLLOWING?**

☐Bleeding or swollen gums ☐ Bad breath ☐ Loose or shifting teeth

☐Sores or irritation in your mouth ☐ Jaw pain ☐ Tension headaches

☐ Teeth clinching or grinding ☐ Trouble chewing ☐ Tooth sensitivity

**IF I COULD CHANGE MY SMILE, I WOULD MAKE MY TEETH:**

☐Whiter ☐ Straighter ☐ Close gaps ☐ Replace silver fillings with tooth- colored restorations

☐Repair chipped tooth ☐ Replace old crowns that do not match

Are you fearful of dental treatment YES ○ NO ○ If yes, what causes this fear? __________

______________________________________________

What can we do to make your visit more comfortable? ______________________

Patient Signature ______________________________ Date: ______________