



New Patient Questionnaire

Patient Name: _____

Please take a moment to write down what you wish to achieve during your visit today and future visits. We want to know what your main concern is so that we can be sure to address it with you.

We know people sometimes wish their teeth or smile were different. Is there anything you would like to discuss about your smile or teeth?

Do you have any sensitive teeth or areas in your mouth?	Yes	No
Are you happy with your bite?	Yes	No
Is your bite comfortable?	Yes	No
Have you ever had TM (Jaw) joint problems?	Yes	No
Do your jaws click or pop?	Yes	No
Have you had braces in the past?	Yes	No
Do you wear a retainer now?	Yes	No
Have you ever been told you have (periodontal) gum disease?	Yes	No
Do you have any cosmetic bonding on your teeth?	Yes	No
Do you wear a night guard for grinding or clenching?	Yes	No
Does the appearance of the silver fillings bother you?	Yes	No
Are you happy with the size and shape of your teeth?	Yes	No
Would you like your teeth to be whiter?	Yes	No