New Patient Dental Questionnaire

Patient Information

First Name *

Last Name *

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New Patient Dental Questionnaire

Relax Dental of Burlington is committed to helping each patient reach their personal dental goals. Please complete the following questionnaire.

What would you rate your smile on a scale of 1-10?

○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

Date of last dental visit?

__/__/____

MM/DD/YYYY

What are your current dental concerns?

What are your dental expectations?

I would rate my previous dental experiences:

○ Great ○ Average ○ Below Average

Tenderness and/or pain?

○ Yes ○ No

☐ Missing teeth?

My concerns are:

☐ Fearful of dental treatment ☐ Financial ☐ Scheduling concerns ☐ Other

☐ Clenching or grinding?

☐ Bleeding or sore gums?

☐ Loose teeth?

☐ Food caught between teeth?

Sign Form

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

☐ I consent to use Electronic Records and Signatures (Read Electronic Record and Signature Disclosure)

Relationship to patient

Name

Signature *

Date

12/04/2024