



**NEW PATIENT QUESTIONNAIRE.**

YOUR NAME:  DATE:

PREFERRED PHONE NUMBER:

How were you referred to us?

In order to evaluate your dental needs and expectations as accurately as possible, please help us by answering the following questions:

Do you have a general dentist that you currently see?  Yes  No

If so, who do you see?

If not, let us know. We have a general dentist here in our office.

When was your last visit?

When was your last X-Ray?

Are you currently experiencing any discomfort in your teeth?

Is there anything about your smile/teeth that you would like to improve?

If yes, Explain.

Do you have any problems chewing?

Do you have any missing teeth you would like to replace?

Are there any dental issues not listed above that you would like to discuss and have treated?

If yes, Explain.

Is there a better time of the day for our office to contact you?