Bruce R. Baumann, D.D.S., F.A.G.D.

Patient's Name____

DENTAL QUESTIONAIRE

Our office is like no other dental office. This will be the most important dental visit you will ever have. We place a high emphasis on helping you determine your present and future needs. Here are some things we are going to be talking about at your first visit. These are issues you have probably never thought of. Please check what best expresses how you feel about the following questions:

- Are you having any areas of concern?____
- Tell us, in your opinion, what you think the present state of the health of your mouth is? ____________________
  ____
- What do you already know about our office and what are your expectations? ____________________
  ____
- How healthy do you want us to get your mouth? (please circle)
  a) Don't really care b) Average c) The best it can be!
- Should you need treatment, at what point should we address it? (please circle)
  a) When my tooth hurts or breaks b) When something is worsening c) When something isn't ideal
- What quality of dentistry do you want us to recommend? (please circle)
  a) Just patch it b) Average c) Ideal, the best
- We have the ability to look at your mouth from 3 different perspectives. What combination of these would you like us to use for you? (please circle)
  a) As a general dentist b) As a cosmetic dentist c) As a functional dentist
- How do you feel about the appearance of your face and smile?____________________
  ____.
- What would it take for you to trust us to be your dentist?____________________
  ____.
- Tell us about your good dental experience____________________
  ____.
- Has fear ever been an issue for you in a dental office? Yes No
- Has time ever been a factor in getting your dental work done? Yes No
- Has the cost of dental treatment been a concern for you? Yes No

  What can we do to help you with this?____

Name of previous Dentist________________________Phone#____________

Is there any additional information you would like us to know? ____________________

____

Continued on reverse side

Indicate which of the following you have had, or have at present.
Circle "yes" or "no" to each item.

Headaches	Yes	No
Jaw Pain	Yes	No
Jaw Popping	Yes	No
Limited opening	Yes	No
Congested ears	Yes	No
Dizziness	Yes	No
Ringing Ears	Yes	No
Loose Teeth	Yes	No
Posture Problems	Yes	No
Clenching	Yes	No
Grinding	Yes	No
Facial Pain	Yes	No
Sensitive Teeth	Yes	No
Neck Ache	Yes	No
Bell's Palsy	Yes	No
Difficulty Swallowing	Yes	No
Difficulty Chewing	Yes	No
Trigeminal Neuralgia	Yes	No
Tingling in arms/fingers	Yes	No
Insomnia/frequent waking	Yes	No

Does floss shred when you use it?	Yes	No
Does food pack or catch between your teeth?	Yes	No
Do you smoke or chew tobacco?	Yes	No
Do your gums bleed?	Yes	No
Does your breath concern you?	Yes	No
Do you consider yourself athletic?	Yes	No

What sports do you currently enjoy?

Would you be interested in improving your strength, balance, flexibility? Yes No

Have you ever heard of The Pure Power Mouthguard? Yes No

Are you aware that 40% of all oral cancers are in non-smokers, non-drinkers under the age of 40? Yes No

Would you be interested in receiving the latest cancer screening for an additional fee? Yes No

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Date

Signature of Patient

Signature of Parent/Guardian