



We would like to get to know you.

How did you hear about Glen Forrest Dental Care? _____

The reason for your visit today? _____

How do you feel about visiting the dentist? (Mark X on the line) Calm----- Tense

When was your last dental visit? _____

We advocate a preventative approach to dentistry. Therefore, we recommend an examination and clean every 6-12 months. How often are you used to attending the Dentist? _____

How would you rate your previous dental experiences? VERY GOOD / GOOD / BELOW AVERAGE / POOR

Why do you give your previous experience this rating? _____

Do you want us to discuss our interest free DentiCare payment plan options with you? YES / NO

How often do you brush your teeth? OCCASIONALLY / ONCE DAILY / TWICE DAILY Do you floss? YES / NO

Do you use an electric or manual toothbrush? _____

How would you rate the condition of your teeth and gums? GOOD / ACCEPTABLE / BELOW AVERAGE

Do you like the general look or aesthetics of your teeth? YES / NO. If no, why? _____

Do you wear dentures? YES / NO. If yes, do you struggle with wearing or eating with your dentures? YES / NO

Do your gums ever bleed when you are brushing your teeth? YES / NO

Are you a smoker? YES / NO Have you been a smoker in the past? YES / NO

Do you ever clench or grind your teeth? YES / NO _____

Do you ever experience a locking or clicking jaw? If yes, how often? YES / NO _____

Do you have any oral piercings? If yes, please list them: _____

Have you had your wisdom teeth extracted? YES / NO

Have you had orthodontic treatment? YES / NO. If yes do you wear a retainer? YES / NO

Sign: _____ Date: _____

ALL INFORMATION IS CONFIDENTIAL