



# Patient Questionnaire

Name

Signature

Date

To help us understand your requirements we would be grateful if you would take a few minutes to answer the questions below

What is your occupation ?

.....

What is your main dental problem at the moment ?

.....

Are there any other problems with your mouth that concern you ?

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Does the appearance of your teeth concern you ?

.....

When did you last have *regular* dental treatment ?

.....

Are you worried or anxious about dental treatment ?

.....

Have there been any particular problems with dental treatment in the past ?

.....

How many times do you brush your teeth per day?

.....

Do you use fluoride supplements such as fluoride mouth rinses?

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Would you say that you take sugary foods or drinks frequently?

.....

Are there any times during the week that you are unavailable for appointments?

.....

Do you play any contact sports ?

.....

Is there anything else about your dental history that you would like us to know?

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Thank you. We look forward to discussing your requirements in more detail at your consultation appointment.