EmblemHealth Family Dental Practice — Oral Health Questionnaire

EmblemHealth Family Dental Practice, 1873 Western Ave., Suite 200, Albany, NY 12203 (518) 869-1044

1. What brings you to the office today? _____

2. When was your last dental visit? _____

3. Do you have any sores, swelling or lumps in your mouth? _____

4. Are your teeth sensitive to any of the following? [ ] Heat? [ ] Cold? [ ] Sweets? [ ] Biting?

5. Are you missing any teeth? [ ] Yes [ ] No
When, how or why? _____

6.	Are you interested in having missing teeth replaced?	[ ] Yes	[ ] No
7.	Do you have removable full dentures or partial dentures?	[ ] Yes	[ ] No
8.	Are you aware of any mouth habits such as:		
	Grinding teeth?	[ ] Yes	[ ] No
	Clenching teeth?	[ ] Yes	[ ] No
	Biting lips, cheeks, tongue?	[ ] Yes	[ ] No
	Biting on foreign objects?	[ ] Yes	[ ] No
	Breathing through your mouth?	[ ] Yes	[ ] No
9.	Do you have or have you ever had any of the following:		
	Fever blisters or cold sores?	[ ] Yes	[ ] No
	Recurrent canker sores or mouth ulcers?	[ ] Yes	[ ] No
	Oral Herpes infection?	[ ] Yes	[ ] No
	Aches in facial muscles?	[ ] Yes	[ ] No
	TMJ pain or problems?	[ ] Yes	[ ] No
	Frequent dry mouth?	[ ] Yes	[ ] No
	Difficulty chewing or swallowing?	[ ] Yes	[ ] No
	Difficulty opening or closing your mouth?	[ ] Yes	[ ] No
	Orthodontic treatment?	[ ] Yes	[ ] No
	Problems with previous dental treatment?	[ ] Yes	[ ] No
	Odors or bad taste in your mouth?	[ ] Yes	[ ] No
	Loose teeth?	[ ] Yes	[ ] No
	Bleeding gums?	[ ] Yes	[ ] No
	Problems with previous dental treatment?	[ ] Yes	[ ] No
	Does food become caught between your teeth?	[ ] Yes	[ ] No
10.	Are you satisfied with the appearance of your teeth?	[ ] Yes	[ ] No
11.	Are you interested in cosmetic dentistry?	[ ] Yes	[ ] No
12.	Do you feel anxious about having dental treatment?	[ ] Yes	[ ] No

Print Patient Name _____

Patient Signature _____ **Date** _____

If signing for a minor, please indicate relationship to patient _____

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