MAXUS DENTAL

New Patient Questionnaire

Name _____ Date _____

In case of emergency who should we contact? _____

Phone number _____ Relationship to patient _____

Reason for seeking dental care at this time _____

How often do you: Brush 1 / 2 / 3 times per day / week Floss 0 / 1 / 2 / 3 times per day / week / month

How do you feel about dental treatment?

☐ Relaxed ☐ A little uneasy ☐ Tense ☐ Anxious ☐ Very anxious

Do you have any of the following:

☐ Periodontal/gum disease ☐ Loose teeth ☐ Areas of food traps ☐ Unfavorable dental experience

☐ Perio cleanings/ treatment ☐ Cold sores ☐ Difficulty opening wide ☐ Growth or lesions in your mouth

☐ Sensitive or bleeding gums ☐ Bad breath ☐ Clicking or popping in jaw ☐ Broken or missing teeth / filling

☐ Grinding or clenching ☐ Swollen glands ☐ Aching / sensitive teeth ☐ Orthodontic treatment

☐ Other

If you could change your smile, what would you change?

☐ Remove unsightly fillings ☐ Change shape of teeth ☐ Close gaps between teeth ☐ Whitening

☐ Straighten teeth ☐ Replace missing teeth ☐ Make teeth same color ☐ Other

I authorize for Maxus Dental to leave a message on my cell /home phone in regards to dental appointment reminders, account balances, after treatment calls, etc. Y or N (circle one)

I authorize for Maxus Dental to text my cell in regards to dental appointment reminders, account balances, after treatment calls, etc. Y or N (circle one)

I authorize for Maxus Dental to send an email in regards to dental appointment reminders, account balances, after treatment calls, etc. Y or N (circle one)

With whom may we share your dental information, for example, but not limited to, appointment times, finances, treatment rendered, etc.

_____relationship to patient_____

Whom may we thank for referring you to our practice? _____