New Patient Questionnaire

Pt Name: ___________________________________

Date: ______________________________________

***Dental History*:**

1. When was your last dental exam? And what was it for? Date: ____________

   Reason for Treatment: ____

2. On a scale of 1 to 10, 10 being most terrified, how would you rate your fear of the dentist? ____

3. What can we do to alleviate your dental fear? _____________________________

   ____

4. Please tell us why you left your last dental office so that we may avoid the same mistake: ____

   ____

5. Who do you prefer to perform your oral hygiene (dental cleanings)?

   Dr. Liao_________ Hygienist_________ Either_________

Social History:

1. Have you ever used tobacco products, including cigarettes and smokeless tobacco? Yes______ No______

2. Are you <u>currently</u> using tobacco products? Yes ______ No ______

   If you answered yes, how often do you use tobacco products? _______________

   ____

3. Have you ever used recreational drugs? Yes ______ No ______

4. Are you <u>currently</u> using recreational drugs? Yes ______ No ______

   If you answered yes, how often do you use recreational drugs? _______________

   ____

5. Many scientific articles have documented the harmful effect of prolonged use of alcohol products on the oral mucosa. Can you tell us how often you drink alcoholic beverages? ____