Hilde Family Dentistry
Jason L. Hilde, D.D.S., P.L.L.C.

Dental Questionnaire / History

1) What are your immediate dental concerns? _____

_____

2) When was your last cleaning? _____

3) Have you ever had gum treatment or surgery for pockets? ☐ Yes ☐ No
If so, where and when? _____

4) If you have missing teeth, are you interested in permanent replacements? ☐ Yes ☐ No

5) If fillings are recommended, which material would you prefer:
☐ Amalgam ("Silver") ☐ Composite ("White") ☐ Porcelain ☐ Gold

6) Are any of your teeth abnormally sensitive to:
☐ Hot ☐ Cold ☐ Biting / Chewing

7) Rate your dental anxiety on a scale of 1 - 10 (10 is the highest): _____

8) Are you interested in medications to lower dental anxiety? ☐ Yes ☐ No

9) Do you experience any pain or soreness in the muscles of your face or around your ear? ☐ Yes ☐ No

10) Do you have frequent headaches? ☐ Yes ☐ No

11) Do you clench or grind your teeth? ☐ Yes ☐ No

12) Are you unhappy with the appearance of your teeth? ☐ Yes ☐ No
If yes, please explain what you are unhappy with: _____

_____

If yes, are you ready to begin treatment on the appearance of your teeth now? ☐ Yes ☐ No