

NEW PATIENT QUESTIONNAIRE

Date: _____ Patient's Name: _____

Referred by: _____

1. Are you experiencing any issues or discomfort with your teeth?

2. When was the last time you saw a dentist? _____

3. Why did you leave your last dentist? _____

4. Was there any particular thing that you liked about your previous dentist or dental visits?

5. Was there any particular thing that you did not like about your previous dentist or dental visits?

6. What do you consider to be the most important factor in making sure that your dental experience is a positive one?

7. What are your goals and desires regarding your dental health?

8. Do you have any particular concerns about your dental care or coming to the dental office?

9. Do you like your smile? _____
10. If you could change something about your smile or teeth what would it be?
