New Patient Interview

Name: _____ Date: _____

1. Tell me about your previous dental experiences (outcome)

2. What would you like us to know in order to work effectively with you? (outcome)

3. In coming to a new dental practice, what kinds of things will be important to you and will insure that you have a good experience here?

4. What are the main issues, challenges, problems you would like us to help you with?

5. What changes have you noticed in your dental condition?

6. What would you hope would stay the same in your mouth?

7. What could we do to help you have a healthier mouth?

Y	N	
❒	❒	Do your gums bleed?
❒	❒	Have you ever had trauma to your face?
❒	❒	Have you ever been diagnosed or treated for TMJ problems?
❒	❒	Has your jaw ever locked open or closed?
❒	❒	Do you grind or clench your teeth? Day or Night?
❒	❒	Do you experience headaches? How often?
❒	❒	Are any of your teeth sensitive to hot, cold or sweets?
❒	❒	Are any of your teeth loose?
❒	❒	Do you have any areas of roughness in your mouth?
❒	❒	Do you have any areas where food gets caught in or around your teeth?

Y	N	
❒	❒	Have you noticed any chipped or worn edges on your teeth?
❒	❒	Are you aware of any discoloration or stain on your teeth?
❒	❒	Are you aware of any unusual odor or taste in your mouth?
❒	❒	Have you ever had any oral surgery? Extractions?
❒	❒	Have you ever had orthodontics?
❒	❒	Have you ever had any injury to your mouth?
❒	❒	Have you ever had periodontal surgery?
❒	❒	Do you snore?
❒	❒	Do you mouth breathe when sleeping?
❒	❒	Do you feel rested after 8 hours of sleep?

New Patient Notes

Name: _____ Date: _____

Personal	Medical	Dental

OUTCOMES

Enter date and appropriate notes

Look Appearance, shape, alignment, wear, spacing	Feel (comfort) Smooth, balanced, pain-free, size	Fit & Function Strength, chew, taste, cleansability	Peace of Mind Durability, precision, thoroughness, confidence, image, trust, fear, investment, health (disease free, body integrity, systemic condition