



Maple Road Dental Practice *Patient Questionnaire*

Name

Signature

Date

To help us understand your requirements we would be grateful if you would take a few minutes to answer the questions below

What is your occupation ?

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What is your main dental problem at the moment ?

.....

Are there any other problems with your mouth that concern you ?

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Does the appearance of your teeth concern you ?

.....

When did you last have *regular* dental treatment ?

.....

Are you worried or anxious about dental treatment ?

.....

Have there been any particular problems with dental treatment in the past ?

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How many times do you brush your teeth per day?

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Do you use fluoride supplements such as fluoride mouth rinses?

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Would you say that you take sugary foods or drinks frequently?

.....

Are there any times during the week that you are unavailable for appointments?

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Do you play any contact sports ?

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Is there anything else about your dental history that you would like us to know?

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Thank you. We look forward to discussing your requirements in more detail at your consultation appointment.