DOMAN
DENTAL CARE

Dental History Questionnaire

What type of dental treatment have you had in the past? _____

Have you ever had any negative dental experiences? _____

Is there anything about your smile that you do not like? _____

Do you like the appearance of your teeth? _____

Is your bite comfortable when chewing, biting? _____

Do you have frequent headaches? _____

Do you have any old fillings or dental treatment that you are unhappy with? _____

Is there anything else you would like us to know? _____

Referral Information

Whom may we thank for referring you to our practice?

- ☐ Friend/Family
- ☐ Work
- ☐ Dental Office
- ☐ Other _____