

JOHN J. BONGHI DDS - TODD L. HAVENS DDS - JOHN A. HAVENS DDS

PRE-CLINICAL EXAMINATION QUESTIONNAIRE

Patient Name _____ Date _____

1. How would you prefer to be addressed by the staff in the office? _____
2. Why did you choose to seek continuing dental care with a new dentist? _____

3. Is there a particular problem that prompted you to make an appointment with us or was this more for routine care? _____
4. What kind of dentistry have you had done in the past? (Circle any that apply) Cleanings, fillings, crowns, bridges, dentures, partials, root canals, cosmetic dentistry, other.
5. How do you feel about the results? _____
6. What do you perceive as your biggest dental problem or dental concern? _____

7. How can we best meet your needs? _____
8. Do you go to the dentist regularly? _____ When was your last checkup? _____
9. Have you ever had a full series of dental x-rays taken? _____ If so, when? _____
10. How often do you have your teeth professionally cleaned? _____ How long does it take? _____
11. Have you ever had any professional instruction in the proper care of your teeth at home? _____
12. What does your daily care of your teeth involve?
 - a. How often do you brush? _____
 - b. What type of brush do you use? _____
(hard, soft, medium, electric)
 - c. Do you use mouth rinse? _____ dental floss? _____ other _____
13. Is there any part of your mouth you avoid brushing because when you brush it is uncomfortable or tender? _____ If so, where? _____
14. Do your gums bleed when you brush? _____ When you floss? _____
15. Are you aware of any unpleasant taste or breath? _____
16. Do you brush your tongue? _____
17. Do you know that you can have gum disease with bone loss and not be aware of it? _____
18. Do you catch food in between your teeth? _____ If so, where? _____

19. Do you have missing teeth? _____ If so, how long have they been missing? _____
Why didn't you have them replaced? _____ Was it suggested? _____
20. Has anyone in your immediate family lost all of their teeth? _____ Why? _____
_____ At what age? _____
21. Do you feel you will eventually lose all of your
teeth? _____ Why? _____
_____ When? _____
22. Do you clench or grind your teeth during the night? _____
23. Do you ever wake up in the morning with a tense or tired feeling in your jaw? _____
24. Do you ever experience aches or pains in the side of your face in the area of your ears
(TMJ)? _____
25. Do you smoke? _____ How much? _____
26. Do you drink coffee or tea? _____ How much sugar do you add? _____ How many cups
per day? _____
27. Do you eat candy, chew gum or drink pop?(circle any that apply). If so, how much? _____
_____, with Nutrasweet or sugar? _____
28. Are you happy with the way your teeth look? _____
29. Have you ever had any dentistry recommended that you didn't have
done? _____

30. Are you uncomfortable going to the dentist? _____ If so, do you know
why? _____
31. Is there anything we can do to make your dental visits more pleasant? _____

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**ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES**

You may refuse to sign this acknowledgement

I, _____, have received a copy of this office's
(signature)
Notice of Privacy Practices.

(please print name)

(signature)

(date)

For office use only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgment
- Other (please specify)

