



NEW PATIENT QUESTIONNAIRE

Patient Name _____

Did you hear about our office from a friend? ☐ Yes ☐ No If yes, who can we thank? _____

If you didn't hear about our office from a friend, how did you hear about our office?

☐ Phone Book ☐ Television ☐ Radio ☐ Newspaper ☐ Location ☐ Other: _____

What is the reason for today's visit? _____

Chief Dental Complaint _____

Have you had any dental treatment recommended that was not completed? _____

What did you like most about any dentist that you have seen? _____

Why did you leave your last dentist? _____

How long since your last dental visit? _____

What was the nature of your last visit? _____

Have you had any serious trouble associated with any previous dental treatment? _____

What did you like least about any dentist you have seen? _____

If you could wave a magic wand and change one thing about your smile, what would it be? _____

Are you interested in whitening your teeth? _____

If you are completing this form for another person, what is your relationship to that person? _____

Sleep Apnea Screening Questions

- | | | |
|---|------------------------------|-----------------------------|
| 1. Have you been told you have sleep apnea and/or already use a CPAP? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. Have you been told that you snore, stop breathing and/or grind your teeth in your sleep? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 3. Are you still tired when you wake up? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 4. Do you have acid reflux and/or high blood pressure? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

305 W. 39th St. South Sioux City, NE 68776 402-494-4924
bridgeviewfamilydental402@gmail.com