



MAXSON DENTAL, P.C.
Gregory M. Maxson, D.D.S.

Dental Health Questionnaire

When was your last dental visit? _____

When were your last x-rays taken? _____

Are you having problems that require immediate attention? _____ if so what? _____

Are your teeth sensitive to hot? _____ Cold? _____ Chewing? _____

How do you take care of your teeth? _____

Do your gums bleed or feel tender or swollen? _____

Does food catch between any of your teeth? _____ If so where? _____

Do you have any broken teeth? _____ If so where? _____

Do you have any missing teeth? _____ If so where? _____

Have they been replaced? ___ With bridge? ___ Implant? ___ Denture? ___ Partial
Denture? _____

Are you happy with your replacements? _____

Are you happy with your smile? _____

Do you have fluoridated water? _____

Have you had orthodontic (braces) treatment? _____

Have you had your wisdom teeth removed? _____

Have you had periodontal (gum) treatment? _____

Does dental treatment make you feel unusually anxious? _____

Do you grind or clench your teeth? _____ If so when? _____

Do you wake up with sore or tight jaw or neck muscles? _____

Do you have frequent headaches? _____

Does your jaw joint ever click, pop or grind? _____
If so, when? _____

Do you have pain in or around your jaw joint or ears? _____

Do your muscles hurt when you chew? _____

Has your jaw ever locked open? _____ Closed? _____

Does your jaw ever slip? _____ Stick? _____

Have you had bad experiences in the dental setting in the past? _____

What is important to you in your oral health? _____

What do you expect from your dental care team? _____

Continued on other side

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