COMMITTED TO EXCELLENCE IN DENTISTRY AND PERSONAL SERVICE

MATTHEW C. PETERSON, D.M.D.
AESTHETIC DENTISTRY

MATT PETERSON, D.M.D.
AESTHETIC DENTISTRY
4729 SWIFT ROAD
SARASOTA, FL 34231
941-926-7726
drmattpeterson.com

DENTAL QUESTIONNAIRE

PATIENT NAME:_____DATE OF BIRTH____/____/____AGE____

My Dental Goals are:

- ☐ Whiter Teeth
- ☐ Pain Free
- ☐ Straighter Teeth
- ☐ Healthier gums
- ☐ Replacing Missing Teeth
- ☐ Full Dentures
- ☐ Cavity free
- ☐ Better Breath
- ☐ Less Bleeding
- ☐ Decrease Sensitivity
- ☐ Partials
- ☐ Better chewing
- ☐ _____
- ☐ _____

1. Why did you leave your other dental practice? _____

2. What do you expect from our practice? _____

3. When was the last time you were seen by a Dentist?_____

4. Have you ever had periodontal treatment? (gum treatment).....☐ Yes ☐ No

5. Do you floss regularly? .....☐ Yes ☐ No

6. Do your gums bleed when you brush or floss?.....☐ Yes ☐ No

If you had a magic wand, what would you change about your smile?_____

_____

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Thank you for completing these new patient forms.
We personalize your dental care based on the answers you've provided.