STOMATOLOGIA
NA PODZAMCZU

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DENTAL JOB INTERVIEW

You can submit the completed form to us in person, send it by post, or email a scanned copy to the following address: rekrutacja@stomatologia.szczecin.pl

Name **Date of birth**

How would you rate the condition of your mouth?

☐ Excellent ☐ Good ☐ Not bad ☐ Bad

Previous dentist _____ How long have you been his/her patient? _____ Months/Years

Approximate date of the last treatment (excluding dental cleaning) _____

I visit the dentist regularly, every: ☐ 3 months ☐ 4 months ☐ 6 months ☐ 12 months ☐ Irregularly

WHAT IS CURRENTLY CONCERNING YOU? _____

PLEASE ANSWER THE FOLLOWING QUESTIONS

	YES	NO
PERSONAL INTERVIEW		
1. Are you afraid of dental treatment? On a scale from 1 (not at all) to 10 (very much)	☐	☐
2. Have you ever had unpleasant experiences at the dentist?	☐	☐
3. Have you ever experienced complications following a previous dental treatment?	☐	☐
4. Have you ever had problems with local anesthesia?	☐	☐
5. Have you ever had braces, orthodontic treatment, or a corrected bite?	☐	☐
6. Have you ever had teeth extracted?	☐	☐
GUMS AND BONE		
7. Does your gum bleed or hurt when you use a toothbrush or dental floss?	☐	☐
8. Have you ever been treated for gum disease, or have you been told that you have bone loss around your teeth?	☐	☐
9. Do you have an unpleasant smell or taste in your mouth?	☐	☐
10. Has anyone in your family had periodontitis?	☐	☐
11. Have you ever experienced gum recession?	☐	☐
12. Have you ever noticed your teeth (or a tooth) moving on their own (without an injury)? Do you have difficulty eating an apple?	☐	☐
13. Do you have a burning sensation in your mouth?	☐	☐
TEETH		
14. Have you had cavities in the past 3 years?	☐	☐
15. Do you feel like you have little saliva in your mouth or difficulty swallowing food?	☐	☐
16. Do you feel or notice holes (e.g., pits) on the chewing surfaces of your teeth?	☐	☐
17. Are your teeth sensitive to: heat, cold, biting, sweets (hot, cold, chewing sweets)? Do you avoid cleaning a specific part of your mouth? Which part?	☐	☐
18. Do you have fissures or indentations at the gumline of your teeth (so-called cervical cavities)?	☐	☐
19. Have you ever had tooth pain, a broken filling, or a chipped, cracked, or fractured tooth?	☐	☐
20. Do food particles get trapped between your teeth?	☐	☐
THE BITE AND THE JAW JOINT		
21. Do you have problems with the jaw joint (e.g., pain, clicking, restricted opening, trismus, or jaw popping)?	☐	☐
22. Do you feel that your lower jaw (mandible) needs to move backward when you bring your upper and lower teeth together?	☐	☐
23. Do you avoid eating foods like baguettes, chocolate bars, or chewing gum, or do you have difficulties with them?	☐	☐
24. Have your teeth changed over the last 5 years (e.g., become shorter, cracked, thinner, damaged, or worn down)?	☐	☐
25. Are your teeth becoming tilted, crowded, thinner, or overlapping?	☐	☐
26. Are your teeth loose or do they have gaps (spaces or gaps between them)?	☐	☐
27. Do you have more than one “bite” and press or shift your teeth to fit them together when you bring your upper and lower teeth together?	☐	☐
28. Do you habitually push your tongue between your teeth, press it against your teeth, or bite your tongue?	☐	☐
29. Do you bite your nails, a pen, hold objects between your teeth, or have other oral habits?	☐	☐
30. Do you grind your teeth during the day or apply force to the point of causing pain?	☐	☐
31. Do you have sleep disturbances, wake up with headaches, or feel a “weird sensation” in your teeth?	☐	☐
32. Do you wear a bite splint or have you ever worn one?	☐	☐
SMILE		
33. Is there anything about your appearance that you would like to change?	☐	☐
34. Have you ever had your teeth whitened?	☐	☐
35. Have you ever felt embarrassed or self-conscious about the appearance of your teeth?	☐	☐
36. Are you dissatisfied with the appearance of previous dental treatments?	☐	☐

Date/Signature of the doctor _____ Date/Signature of the patient _____