**DENTAL HISTORY** **Gretchen Kinchen, DMD**

Today's Date _____/_____/_____

Patient's Name _____ Date of Birth _____/_____/_____

Date and reason for last dental visit _____

When were your last dental x-rays taken? _____

Name of previous dentist _____

Identify any current concerns (be sure to address them).

_____

**APPREHENSION**

Is there any specific thing that worries you about having dental treatment performed? ☐ Yes ☐ No
Describe _____

Have you ever experienced complications with any dental treatment? ☐ Yes ☐ No

Have you ever received laughing gas or nitrous during a dental visit? ☐ Yes ☐ No
Would you like to have it here in this office? _____

Have you received any other kind of sedation for dental treatment including valium or other medications? ☐ Yes ☐ No
Describe _____

Do you feel you need any help overcoming fear of having dental treatment? ☐ Yes ☐ No

**COSMETICS**

If you could change anything about your smile, what would it be?

_____

_____

Have you ever worn braces or received any orthodontic treatment? ☐ Yes ☐ No

Record shade _____

**PERIODONTAL HEALTH**

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

Are your gums red, swollen or tender? ☐ Yes ☐ No

Do you ever have trouble with a bad taste in your mouth or bad breath? ☐ Yes ☐ No

Do your gums pull away from your teeth? ☐ Yes ☐ No

Have any of your teeth drifted, separated or become loose? ☐ Yes ☐ No

Did either of your parents lose their teeth due to gum disease? ☐ Yes ☐ No

Have you ever been treated for gum disease? ☐ Yes ☐ No

Does food tend to wedge between any of your teeth? ☐ Yes ☐ No

Do you have any area that is hard to floss? ☐ Yes ☐ No

**OCCLUSION AND TMJ**

Has there been any change in the way your teeth fit together when you chew or bite? ☐ Yes ☐ No

Do you ever have headaches? ☐ Yes ☐ No

Have you ever had an injury to your face, head or neck? ☐ Yes ☐ No

Does your jaw ever pop or crack? ☐ Yes ☐ No

Do your jaw or facial muscles ever get tired or sore? ☐ Yes ☐ No
If so, when do you notice it? _____

**MISSING TEETH**

Do you have any missing teeth? ☐ Yes ☐ No
If so, how long have they been missing? _____

Have you ever had these teeth replaced? ☐ Yes ☐ No
When were they replaced? _____

Do you presently wear any partials or dentures?
☐ Yes ☐ No If so, for how long? _____

When was your current denture (partial) made? _____

Do you have any trouble chewing or speaking? ☐ Yes ☐ No

**EXISTING RESTORATIVE**

Are any of your teeth sensitive to hot, cold, sweets or the pressure of biting down? ☐ Yes ☐ No

Are there any areas of your mouth that you can't or don't like to chew on? ☐ Yes ☐ No

If patient has crowns or bridges, when were they made?

_____

**MISCELLANEOUS**

Is there anything we can do in our office to make your dental experience a good one? ☐ Yes ☐ No
If so, what is it? _____

_____

Is your drinking water fluoridated? ☐ Yes ☐ No
Do you drink bottled water or tap water? ☐ Yes ☐ No

Do you drink carbonated beverages? ☐ Yes ☐ No

**COMMENTS**

Staff member: Is there anything that is going to stand in the way of the patient getting the treatment that he/she needs?

_____

_____

_____

Your initials: _____