



YOUR CHILD'S DENTAL HISTORY AND HABITS

Your Child's name _____ Nickname _____ Date _____

Welcome! So that we may provide you child with the best possible care, please complete both sides if this dental/medical history form. All information is completely confidential. Please be sure to answer individually any yes or no questions.

What is the reason for your visit today? _____

Your Child's Previous Dentist: Name _____ Telephone _____

Address _____ City _____ State _____ Zip _____

Date of your child's last dental visit _____ Last dental cleaning _____ Last full mouth x-rays _____

How often does your child brush? _____ Floss? _____ Do you assist?..... Yes No

Is your child's water fluoridated?..... Yes No Does your child take fluoride supplements?..... Yes No

Does your child have any dental problems now?..... Yes No If yes, please describe _____

How do you think your child will do?..... Good Fair Poor

Has your child had difficulty with previous dental visits? Yes No If yes, please describe _____

Has your child complained about dental problems? Yes No If yes, please describe _____

Has your child ever worn orthodontic appliances? Yes No If yes, please describe _____

Are any of your child's teeth sensitive to:

Hot or cold?..... Yes No

Sweets?..... Yes No

Biting or Chewing?..... Yes No

Does your child engage in:

Sucking thumb or fingers?..... Yes No

Biting or sucking lips or cheeks?..... Yes No

Grinding teeth?..... Yes No

Mouth breathing?..... Yes No

Chewing or biting fingernails?..... Yes No

Chewing hard objects (e.g. pencils).... Yes No

Clenching jaw?..... Yes No

Nursing bottle or pacifier habits?..... Yes No

Do your child's gums bleed or hurt?..... Yes No

Does your child have any pain or tenderness in the jaw joint, ear, side of face..... Yes No

Do you have any special concerns about your child's dental health: Yes No If yes, please describe _____
