Your Child's Dental History and Habits

Your Child's Name _____ **Nickname** _____ **Date** _____

Welcome! So that we may provide your child with the best possible care, please complete both sides of 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 _____

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