

Child's Dental History



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

What is the reason for your visit today? _____

Has your child ever been to the dentist? _____

Name of previous Dentist: _____ Phone #: _____

Address: _____

Date of your child's last visit? _____ Last x-rays? _____

How often does your child brush? _____ Floss? _____ Do you assist? _____

Is your child's water fluorinated? _____ Does your child take fluoride supplements? _____

Does your child have any dental problems now? _____ If yes, please describe _____

Does your child have issues with the dentist? _____

Has your child ever complained about any dental problems? _____

Are your child's teeth sensitive to: Hot or Cold? _____ Sweets? _____ Biting/Chewing? _____

Does your child ever:

Suck his/her thumb? _____ Chew/Bite Nails? _____

Biting/Sucking Lips or Cheeks? _____ Clenching Jaw? _____

Grinding of teeth? _____ Pacifier habits? _____

Do you your child's gums hurt or bleed? _____

Do you have any concerns about your child's dental health overall? _____

