Patient Number _____

Patient's Name _____
Last First Initial Date of Birth

Parent's Name _____
Last First Initial

Child's Dental History

1. Is this the child's first visit to the dentist? ..... Y N
2. If not, how long since the last visit to the dentist? _____
3. Previous dentist's name _____
4. Were dental x-rays taken? ..... Y N
5. Does child eat between meals? ..... Y N
6. Does child eat sweets, such as candy, soda pop, chewing gum? ..... Y N
7. Does child eat well balanced meals? ..... Y N
8. Does child brush teeth after meals? ..... Y N
   when going to bed? ..... Y N
   after eating any food? ..... Y N
10. Have teeth been treated with fluorides? ..... Y N
11. Have any cavities been noted in the past? ..... Y N
12. Were any teeth (baby or permanent) removed by extraction? ..... Y N
    was it suggested that the space be maintained? ..... Y N
    was appliance placed? ..... Y N
13. Does child clench or grind their teeth? ..... Y N
14. Does the jaw click or pop? ..... Y N
15. Have any discolored teeth been bleached? ..... Y. N
16. Have any cosmetic bonding procedures been done? ..... Y N
17. Has child ever had occlusal sealants? ..... Y N
18. Have there been any injuries to teeth, such as falls, blows, etc.? ..... Y N
    If so, describe _____
19. Has child had any unfavorable dental experiences? ..... Y N
20. How many children in your family? .....
21. Has anyone in the family, including parents, had orthodontics? ..... Y N
22. Has child ever received a local anesthetic? ..... Y N

Comments

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

Parent's/Guardian's Signature _____ Date _____

Dentist's Signature _____ Date _____

CHILD DENTAL HISTORY