Family & Cosmetic Dentistry

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CHILD'S DENTAL HISTORY

Child's Name: ______________________________ Age: ____________________________ Parent/Guardian: ________________________

Child's previous Dentist: ____ Phone Number: ______________________________________

Most recent dental examination: ________________________________ Most recent dental x-rays: _________________________________

Why did you bring the child to the dentist today? ____

____

Does the child need to be premedicated before dental treatment? ☐ Yes ☐ No

Is the child currently in pain? ☐ Yes ☐ No

Has the child ever had a serious / difficult Problem associated with any previous dental work? ☐ Yes ☐ No

Has the child ever experienced pain / discomfort / in his / her jaw Joint (TMJ / TMD)? ☐ Yes ☐ No

Current dental health is ☐ Good ☐ Fair ☐ Poor

Floss daily? ☐ Yes ☐ No

Brush daily ☐ Yes ☐ No

Mouth Rinse ☐ Yes ☐ No

Does the child's gums ever bleed? ☐ Yes ☐ No

Are his / her teeth sensitive to heat or cold? ☐ Yes ☐ No

Are his / her teeth sensitive to sweets? ☐ Yes ☐ No

Are his / her teeth sensitive to chewing? ☐ Yes ☐ No

Has the child lost any teeth accidentally? ☐ Yes ☐ No

If yes, how? ____

Does the child play sports? ☐ Yes ☐ No

Is the child's water Fluoridated? ☐ Yes ☐ No

Does / did the child have any of the following habits?

	YES	No		Yes	No		Yes	No
Lip Sucking / Biting _____	☐	☐	Clenching / Grinding Teeth __	☐	☐	Speech Problems __	☐	☐
Nail Biting ____________	☐	☐	Thumb Sucking ____________	☐	☐	Other ___________	☐	☐
Tongue / Cheek Biter ___	☐	☐	Mouth Breather ___________	☐	☐			

If Other please explain: ____

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN THE CHILD'S MEDICAL HISTORY OR ANY MEDICATIONS THE CHILD MAY BE TAKING.

I understand the information that I have given is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence, and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services that my child may need.

Parent/Guardian Signature: ____ Date: ____________________________