

**CHILD DENTAL HISTORY**

Patient's First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Nickname: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Parent/Guardian name: \_\_\_\_\_

Responsible Party: \_\_\_\_\_

**YOUR CHILD'S DENTAL HISTORY**

1. Is this your child's first visit to the dentist? \_\_\_ Yes \_\_\_ No
2. If not, when was his/her last visit? \_\_\_ Years \_\_\_ Months
3. Were x-rays taken at any of the previous visits \_\_\_ Yes \_\_\_ No
4. Does your child eat between meals? \_\_\_ Yes \_\_\_ No
5. Does your child eat sweets, such as candy, soda, or chewing gum? \_\_\_ Yes \_\_\_ No
6. When does your child brush their teeth?  
Morning \_\_\_\_\_, After meals \_\_\_\_\_, After eating snacks \_\_\_\_\_, Bedtime \_\_\_\_\_
7. How does your child receive fluoride?  
Community water \_\_\_\_\_, Well water \_\_\_\_\_, Fluoride drops or tablets \_\_\_\_\_  
Fluoride Rinse or Gel \_\_\_\_\_, Other \_\_\_\_\_
8. Have cavities been noted in the past? \_\_\_ Yes \_\_\_ No
9. Were any teeth removed by extraction? \_\_\_ Yes \_\_\_ No  
Baby teeth \_\_\_\_\_,  
Permanent teeth \_\_\_\_\_
10. Have there been any injuries to teeth in the past, such as: \_\_\_ Yes \_\_\_ No  
Falls \_\_\_\_\_, Chips \_\_\_\_\_, Blows \_\_\_\_\_ or other \_\_\_\_\_
11. Has your child had any problem with dental treatment in the past? \_\_\_ Yes \_\_\_ No
12. Has your child had orthodontic/braces? \_\_\_ Yes \_\_\_ No
13. Has anyone in the family had orthodontics? \_\_\_ Yes \_\_\_ No
14. Has your child ever had occlusal sealants? \_\_\_ Yes \_\_\_ No
15. Does your child think there is anything wrong with his/her teeth? \_\_\_ Yes \_\_\_ No
16. Are there any other concerns or comments you would like us to be aware of or address? \_\_\_ Yes \_\_\_ No

\_\_\_\_\_  
\_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Dentist Signature: \_\_\_\_\_ Date: \_\_\_\_\_