Dental History

What is your primary concern about your child's oral health?

How would you describe your child's oral health?

Please select...

Is there a family history of cavities?

Yes

No

Please indicate if your child has a history of any of the following:

Problems with eruption and shredding of teeth?

Yes

No

Mouth sores or fever blisters

Yes

No

Bad breath

Yes

No

Bleeding gums

Yes

No

Cavities/decayed teeth

Yes

No

Toothache

Yes

No

Injury to teeth, mouth or jaws

Yes

No

Clenching/grinding his/her teeth

Yes

No

Jaw joint problems (popping, etc.)

Yes

No

Excessive gagging

Yes

No

Does the child suck his/her thumb, fingers, or pacifier?

Yes

No

Brushing and Flossing

How often does your child brush his/her teeth?

Please select...

Does someone help your child brush?

Yes

No

How often does your child floss his/her teeth?

Please select...

Does someone help your child floss?

Yes

No

Is your child using toothpaste with fluoride?

Yes

No

Water and Fluoride

Do you use a water filter at home?

Yes

No

Please check all sources of fluoride your child receives:

Fluoride treatment in the dental office

Fluoride varnish by pediatrician/other practitioner

Prescription drops/tablets/vitamins

Toothpaste

Over-the-counter rinse

Prescription rinse/gel

None

Other

Dietary Habits

Does your child regularly eat 3 meals each day?

Yes

No

Is your child on a special or restricted diet?

Yes

No

Is your child a "picky eater"?

Yes

No

Does your child have a diet high in sugars or starches?

Yes

No

Do you have any concerns regarding your child's weight?

Yes

No

Please select how frequently your child has the following:

Candy or other sweets

Please select...

Chewing gum

Please select...

Snacks between meals

Please select...

Soft drinks/Juice

Please select...

Please note other significant dietary habits

Sports and Activities

Does your child participate in any sport or similar activities?

Yes

No

Does your child wear a mouthguard during these activities?

Yes

No

Previous Dental Treatment

Has your child been examined or treated by another dentist?

Yes

No

Were x-rays taken of the teeth or jaws?

Yes

No

Has your child ever had orthodontic treatment (braces, spacers, or other appliances)?

Yes

No

Has your child ever had a difficult dental appointment?

Yes

No

How do you expect your child will respond to dental treatment?

Please select...

Is there anything else we should know before treating your child?

Patient's Signature

create

Draw signature here

Relationship to the patient

Please select...