

# Your Child's Dental History and Habits

Your Child's Name \_\_\_\_\_ Nickname \_\_\_\_\_ Date \_\_\_\_\_

**Welcome!** So that we may provide your child with the best possible care, please complete both sides of this dental/ medical history form. All information is completely confidential. Please be sure to answer individually any yes or no questions

What is the reason for your visit today? \_\_\_\_\_  
\_\_\_\_\_

Your Child's Previous Dentist: Name \_\_\_\_\_ Telephone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Date of your child's last dental visit \_\_\_\_\_ Last dental cleaning \_\_\_\_\_ Last full mouth x-rays \_\_\_\_\_

How often does your child brush? \_\_\_\_\_ Floss? \_\_\_\_\_ Do you assist? .....  Yes  No

Is your child's water fluoridated? .....  Yes  No Does your child take fluoride supplements? .....  Yes  No

Does your child have any dental problems now? .....  Yes  No If yes, please describe \_\_\_\_\_  
\_\_\_\_\_

How do you think your child will do? .....  Good  Fair  Poor

Has your child had difficulty with previous dental visits? .....  Yes  No If yes, please describe \_\_\_\_\_

Has your child complained about dental problems? .....  Yes  No If yes, please describe \_\_\_\_\_

Has your child ever worn orthodontic appliances? .....  Yes  No If yes, please describe \_\_\_\_\_

Are any of your child's teeth sensitive to:

Hot or cold? .....  Yes  No Sweets? .....  Yes  No Biting or Chewing? .....  Yes  No

Does your child engage in:

Sucking thumb or fingers? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Chewing or biting fingernails? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No
Biting or sucking lips or cheeks? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Chewing hard objects (e.g., pencils)? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No
Grinding teeth? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Clenching jaw? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No
Mouth breathing? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Nursing bottle or pacifier habits? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No

Do your child's gums bleed or hurt? .....  Yes  No

Does your child have any pain or tenderness in the jaw joint, ear, side of face? .....  Yes  No

Do you have any special concerns about your child's dental health?  Yes  No If yes, please describe \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_