Child's Dental History

Comments

1. What is the reason for your child's visit?_____
2. Is this your child's first time to visit a dentist? ..... Yes No
3. Do you brush your child's teeth? ..... Yes No
4. Does your child brush his/her own teeth? ..... Yes No
5. Does your child suck his/her thumb or fingers? ..... Yes No
6. Does your child eat candy or other sweets or drink soda pop . ..... Yes No
7. Has your child ever had a head injury? ..... Yes No
8. Has your child ever had any injuries to his/her teeth, chin or jaws . ..... Yes No
9. Is your child afraid to visit the dentist? ..... Yes No
10. Has anyone in your family ever had orthodontic treatment? ..... Yes No
11. Does your child like the appearance of his/her teeth? ..... Yes No
12. Would you like to discuss anything else with the dentist about your child's teeth? ..... Yes No

Please answer the following questions if your child has seen another dentist elsewhere.

13. What treatment was done for your child? _____
14. When was this treatment done? _____
15. What best describes your child's behavior in the previous dental office?
    ☐ helpful ☐ fearful, but helpful ☐ extremely fearful; was not able to cooperate

Dental Education Questions: Did you know that...

1. ... putting your child to sleep with a bottle can cause tooth decay? ..... Yes No
2. ... soda pop can cause your child to have tooth decay? ..... Yes No
3. ... a child 1-4 years old needs an adult to brush and floss his teeth? ..... Yes No
4. ... a child 5-7 years old needs an adult to supervise the brushing and flossing of his teeth? ..... Yes No
5. ... you need to bring a child for a first visit to the dentist as soon as teeth erupt? (about 6-9 months) ..... Yes No
6. ... you should bring your child to see the dentist every 6 months for check-up, cleaning, and fluoride treatments? Yes No
7. ... the dental professionals in our clinic care about your child's oral health? ..... Yes No

Update Information (Office Use Only)

Date	*Comment*	*Initials*	*Date*	*Comment*	*Initials*

DO YOU HAVE ANY QUESTIONS? PLEASE ASK US!

Parent/Guardian's signature _____ Date _____

Dentist's signature _____ Date _____

Witness/Interpreter's signature _____ Date _____

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