



## Child's Dental History

### Section Title Goes Here

<b>Child's Name:</b>	<b>Age:</b>
<b>Parent/Guardian:</b>	<b>Child's previous Dentist:</b>
<b>Phone Number:</b>	<b>Most recent dental examination:</b>
<b>Most recent dental x-rays:</b>	
<b>Why did you bring the child to the dentist today?</b>	
<b>Current dental health is:</b>	
<input type="checkbox"/> Good	<input type="checkbox"/> Fair <input type="checkbox"/> Poor
<b>Please answer yes or no to the following:</b>	
<b>Does the child need to be premedicated before dental treatment?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Is the child currently in pain?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Has the child ever had a serious / difficult Problem associated with any previous dental work?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Has the child ever experienced pain / discomfort / in his / her jaw Joint (TMJ / TMD)?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Floss daily?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Brush daily?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Mouth Rinse?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Does the child's gums ever bleed?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Are his / her teeth sensitive to heat or cold?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Are his / her teeth sensitive to sweets?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Are his / her teeth sensitive to chewing?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Does the child play sports?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Is the child's water Fluoridated?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Has the child lost any teeth accidentally?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>If Yes, how?</b>	

<b>Does / did the child have any of the following habits?</b>			
<b>Lip Sucking / Biting</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Nail Biting</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>Tongue / Cheek Biter</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Clenching / Grinding Teeth</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>Thumb Sucking</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Mouth Breather</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>Speech Problems</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Other</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>If other, please explain:</b>			
PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN THE CHILD'S MEDICAL HISTORY OR ANY MEDICATIONS THE CHILD MAY BE TAKING			
<b>Parent/Guardian Signature:</b>			
<b>I agree that the above field represents my signature.</b> <input type="checkbox"/>			
<b>Date:</b>			