Family & Cosmetic Dentistry
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Child's Dental History

Section Title Goes Here

Child's Name:	**Age:**
Parent/Guardian:	**Child's previous Dentist:**
Phone Number:	**Most recent dental examination:**
Most recent dental x-rays:	
Why did you bring the child to the dentist today?	
Current dental health is: ❑ Good ❑ Fair ❑ Poor	

Please answer yes or no to the following:

Does the child need to be premedicated before dental treatment?	❑ Yes	❑ No	**Is the child currently in pain?**	❑ Yes	❑ No
Has the child ever had a serious / diffcult Problem associated with any previous dental work?	❑ Yes	❑ No	**Has the child ever experienced pain / discomfort / in his / her jaw Joint (TMJ / TMD)?**	❑ Yes	❑ No
Floss daily?	❑ Yes	❑ No	**Brush daily?**	❑ Yes	❑ No
Mouth Rinse?	❑ Yes	❑ No	**Does the child's gums ever bleed?**	❑ Yes	❑ No
Are his / her teeth sensitive to heat or cold?	❑ Yes	❑ No	**Are his / her teeth sensitive to sweets?**	❑ Yes	❑ No
Are his / her teeth sensitive to chewing?	❑ Yes	❑ No	**Does the child play sports?**	❑ Yes	❑ No
Is the child's water Fluoridated?	❑ Yes	❑ No	**Has the child lost any teeth accidentally?**	❑ Yes	❑ No

If Yes, how?

Does / did the child have any of the following habits?

Lip Sucking / Biting	❑ Yes	❑ No	**Nail Biting**	❑ Yes	❑ No
Tongue / Cheek Biter	❑ Yes	❑ No	**Clenching / Grinding Teeth**	❑ Yes	❑ No
Thumb Sucking	❑ Yes	❑ No	**Mouth Breather**	❑ Yes	❑ No
Speech Problems	❑ Yes	❑ No	**Other**	❑ Yes	❑ No

If other, please explain:

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN THE CHILD'S MEDICAL HISTORY OR ANY MEDICATIONS THE CHILD MAY BE TAKING

Parent/Guardian Signature:

Date: