## DENTAL HISTORY

Is This the first visit to a dentist? N ☐ Y ☐ If NO when was your child's last dental visit? _____

Dentist(s) Name (Please List): _____

Dentist(s) Phone _____ Were X-Rays taken N ☐ Y ☐

What is your SPECIFIC Concern? _____

Is there NOW or has there EVER BEEN any of the following?

| | PAST | PRESENT | | |
|---|---|---|---|---|
| Cavities | ☐ | ☐ | When _____ | |
| Extractions | ☐ | ☐ | When _____ | |
| Mouth Injuries | ☐ | ☐ | When _____ | |
| Orthodontics | ☐ | ☐ | Dentist_____ | When _____ |
| Toothache | ☐ | ☐ | When _____ | How Long _____ |
| Gum Infection | ☐ | ☐ | When _____ | How Long _____ |
| Pacifier, Thumb, Or Finger Sucking | ☐ | ☐ | Until What Age _____ | |
| Lip Sucking | ☐ | ☐ | Until What Age _____ | |
| Teeth Grinding | ☐ | ☐ | Until What Age _____ | |
| Nail Biting | ☐ | ☐ | Until What Age _____ | |
| Tobacco Use | ☐ | ☐ | What Type _____ | Frequency _____ |
| Oral Piercings | ☐ | ☐ | Location _____ | |
| Breast/Bottle Feed | ☐ | ☐ | Until What Age _____ | |

**PLEASE CIRCLE ALL THAT APPLY:**

Your Child Drinks: Well Water, Bottled Water, Filtered Water? (Brand /Type)_____

Does your child use a fluoride supplement? (rinse, tablet) N ☐ Y ☐

If Yes, Please State Brand And Dosage: _____

At what age did you start brushing your child's teeth? _____

Who Brushes Your Child's Teeth? _____ How Many Times Per Day?_____

What Brand Of Toothpaste Does Your Child Use?_____

Does Your Child Spit Or Swallow The Toothpaste? _____

Does Your Child Use Dental Floss? N ☐ Y ☐ Does your child use mouth rinse? N ☐ Y ☐

Does Your Child Use A Mouthguard For Sports? N ☐ Y ☐

Has Your Child Had An Unfavorable Medical Or Dental Experience? N ☐ Y ☐ If yes, Please Explain:

_____

Please Describe Your Child's Personality: _____

Please Add Anything Concerning Your Child's Dental Or Medical History That You Feel May Be Important:

_____

**Authorization, Release and Consent:**

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. I understand this information will be used by the dentist to help provide appropriate and healthful dental treatment. My responsibility is to inform the dentist of any changes in my child's medical status. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to my child during the period of such dental care to third party payers and/or other health practitioners.

I hereby give my consent for the dental examination and treatment of my child. This dental exam may include diagnostic x-rays, photographs, and/or study models as deemed necessary for a comprehensive diagnosis.

**PLEASE NOTE: PARENT OR LEGAL GUARDIAN MUST BE PRESENT FOR THE INITIAL APPOINTMENT.**

_____ _____ _____

Name of patient Signature of Parent/Guardian Date