PEDIATRIC DENTAL HISTORY

Please circle the correct answer:

Yes No Has your child ever been to the dentist?

Date of last cleaning and x-rays (if taken) ___________________________________

Name of previous dentist _________________________ Phone # ________________

Yes No Have previous dental experiences been positive?

If no, please explain ____

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Yes No Has your child had any complications from past dental treatment?

Yes No Is your child currently experiencing any dental discomfort?

If yes, please explain ____

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Yes No Have your child's teeth ever been injured? Which teeth? When? _____________

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Yes No Is there any family history of missing teeth?

Yes No Does your child snore?

Yes No Does your child grind their teeth?

Yes No Has your child ever been seen by an orthodontist? Which one? _______________

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Yes No Does your child play any sports? Which ones? _____________________________

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Do you have any other dental information or concerns? _____________________

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Parent's signature ____ **Date** _____________________

Dentist's signature _______________________________________ **Date** _____________________