



Your Child's Dental History

Date of last visit to dentist _____ Child's age _____

What service did child have done _____

Has child complained about dental problems _____

Any unhappy dental experiences _____

Any injuries to mouth - teeth or head _____

Any mouth habits - thumb sucking - nail biting - mouth breathing - nursing bottle habits- pacifier etc.

Any unusual speech habits _____

Any lost teeth _____

Have missing teeth been replaced _____

Orthodontic appliances worn now or ever been worn _____

Does your child brush teeth daily _____ How often _____

Do you assist child when tooth brushing _____

Is dental floss used _____ How often _____

Are disclosing tablets used _____ How often _____

Is fluoride taken in any form _____

Do you have any concerns you would like us to know about _____

What is your child's favorite...

Sport _____

Toy _____

Hobby _____

Person _____

Movie _____

Character _____

Color _____