CHILD DENTAL HISTORY

Patient Name:	D.O.B.	M	D	Y	Patient/Parent/Guardian Initial:	Date:	M	D	Y

GENERAL CONSENT FOR TREATMENT: I, the undersigned, certify that I have provided an accurate and complete personal and medical/dental history and have not knowingly omitted any information. I have had the opportunity to ask questions and receive answers to any questions regarding my child's medical and dental histories. Should there be any change to either my child's health status or any other information I have provided, I will advise this dental office. I understand that information provided from or to my child's medical doctor or another health care provider may be necessary. I authorize the dentist to perform diagnostic procedures as may be required to determine necessary treatment.

X ____ ______________________________ ______________

Signature of (circle one) Parent/Guardian Print Name of Parent/Guardian Date

____ _________________

Signature of Treating Dentist Date

CHILD DENTAL HISTORY (Age 0 to 15): Please circle YES or NO to each question. If unsure, please consult with the dentist.

1. Is this your child's first visit to the dentist? YES/NO
2. When was their last dental visit? _______________ Last cleaning? ______________ Last dental x-rays? ______________
3. Has your child ever had any of the following? If you answer "YES" please list when.
   - Dental work using freezing and/or nitrous oxide ("laughing gas") _______________________________________ YES/NO
   - Dental work while asleep or sedated, in the dental office or in the hospital? _______________________________ YES/NO
   - Dental work by a children's specialist/paedodontist? ____ YES/NO
   - Teeth removed by a dentist/dental specialist? ____ YES/NO
   - Orthodontic Treatment (braces/retainer/appliance to straighten or realign teeth)? __________________________ YES/NO
4. How often does your child brush his/her teeth? ______________________ Do you help them with brushing? YES/NO
5. Is your child having pain in their mouth? ____ YES/NO

   Where/When? ____
6. Does your child:
   - Grind their teeth? YES/NO
   - Bite their fingernails? YES/NO
   - Mouth breathe? YES/NO
   - Chew on their cheeks or lips? YES/NO
   - Suck their thumb/fingers? YES/NO
   - Use a soother? YES/NO
7. Does having dental &/or medical treatment make your child feel nervous or uncomfortable? _______________________ YES/NO
8. Has your child ever had an upsetting experience at the dentist? ____ YES/NO
9. Do you feel it is important for your child to have healthy baby (primary) teeth? __________________________________ YES/NO