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| Patient Name: _____ <div style="display: flex; justify-content: space-around; font-size: small;"> LAST FIRST MIDDLE </div> | Date of Birth: ____/____/____ |
|--|-------------------------------|

DENTAL HISTORY

| | YES | NO |
|---|--------------------------|--------------------------|
| Is this your child's first visit to the dentist? | <input type="checkbox"/> | <input type="checkbox"/> |
| If no, what is the | | |
| • Date of last dental visit _____ | | |
| • Date of last X-rays _____ | | |
| Is your child having a problem now? | <input type="checkbox"/> | <input type="checkbox"/> |
| What is the reason of today's visit? | | |
| Do you or does your child have any concerns about your child's dental health? | <input type="checkbox"/> | <input type="checkbox"/> |
| Has your child had any previous unfavorable dental or medical experiences? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you think your child will be upset by dental treatment? | <input type="checkbox"/> | <input type="checkbox"/> |
| Are you nervous about this appointment? | <input type="checkbox"/> | <input type="checkbox"/> |
| Has your child had toothaches in the past? | <input type="checkbox"/> | <input type="checkbox"/> |
| Has your child ever had injuries to teeth, mouth, or face? | <input type="checkbox"/> | <input type="checkbox"/> |
| Has your child ever had a problem with grinding/clenching his/her teeth? | <input type="checkbox"/> | <input type="checkbox"/> |
| Has your child ever complained about clicking his/her jaw? | <input type="checkbox"/> | <input type="checkbox"/> |

PREVENTIVE ASSESMENT

| | YES | NO |
|--|--------------------------|--------------------------|
| Does your child use a pacifier or suck a thumb or finger? | <input type="checkbox"/> | <input type="checkbox"/> |
| Does your child sleep with a bottle? | <input type="checkbox"/> | <input type="checkbox"/> |
| Is your child on a special diet? | <input type="checkbox"/> | <input type="checkbox"/> |
| Does your child brush his/her own teeth? | <input type="checkbox"/> | <input type="checkbox"/> |
| Does an adult help with brushing? | <input type="checkbox"/> | <input type="checkbox"/> |
| Does your child use floss? | <input type="checkbox"/> | <input type="checkbox"/> |
| Does your child's gum bleed when brushed? | <input type="checkbox"/> | <input type="checkbox"/> |
| Does your child use fluoridated toothpaste daily? | <input type="checkbox"/> | <input type="checkbox"/> |
| Is your water supply fluoridated? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you use bottled water, or a water filtration system? | <input type="checkbox"/> | <input type="checkbox"/> |
| Has your child used fluoride supplements? | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, please list: | | |
| | | |
| Does your child eat snacks high in sugar (candy, soda etc.)? | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, how often? | | |
| | | |