

Child Dental History

Patient's Name: _____

Date: _____

Dental History:

Name of Dentist: _____

Dentist Phone #: _____

Date of your child's most recent dental examination by your dentist? Month: _____ Year: _____

Does your child brush his/her teeth daily? Yes No

Does your child floss his/her teeth daily? Yes No

Do you like your child's smile? Yes No

If no, please explain: _____

Have adenoids/tonsils been removed? Yes No

If yes, please explain: _____

Has your child been informed of any missing or extra permanent teeth? Yes No

If yes, please explain: _____

Has your child ever had serious/difficult problems associated with any previous dental work? Yes No

If yes, please explain: _____

Does your child currently plan to have any dental work completed? Yes No

If yes, please explain: _____

Orthodontic Survey:

What are the main concerns that you would like orthodontics to accomplish? _____

Has your child ever been evaluated or had orthodontic treatment? Yes No

If yes, please explain: _____

Has your child ever had an injury to any of the following? Yes No

If yes, please circle and explain: Mouth Teeth Chin

Has your child ever had any pain/tenderness in your jaw joints (TMJ/TMD)? Yes No

If yes, please explain _____

Is there any family history of (TMJ/TMD) symptoms? Yes No

If yes, please explain _____

Do you notice your child clenching/grinding their teeth? Yes No

If yes, please explain: _____

I understand that the information that I have given today concerning my child is correct to the best of my knowledge. I also understand that this information will be held in the confidence, and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services with my informed consent that I may need during diagnosis and treatment.

Signature of parent or guardian: _____

Date: _____