

CHILD DENTAL HISTORY

Patient Name: _____ **Age:** _____ **Date:** _____

Is this your child's first visit to a dentist? Yes No

If not, how long since the last visit to the dentist? _____
What was done at that time? _____

Is your child having a dental problem at this time? Yes No
If yes, please describe: _____

When does your child brush his/her teeth?
 upon arising right after meals before going to bed

Have any cavities been noted in the past? Yes No

Have there been any injuries to the teeth (i.e. falls, chips, blows, etc.) Yes No
If yes, please describe: _____

Has your child had any problems with dental treatment in the past? Yes No

Has your child ever received local anesthetic? Yes No

Has your child ever had Nitrous Oxide (laughing gas)? Yes No

Does your child think there is anything wrong with his/her teeth? Yes No

Comments: _____
