HK DIA PI NI

Patient's Name: _____ Date of Birth: _____
M?D?Y

All of the information which you provide on this form will be held in the strictest confidence. Although some questions may seem unimportant at this time, they may be vital in an emergency situation. Please answer each question. Use the reverse of this page if you require more space.

DENTAL HISTORY

1. Has your child previously seen a dentist? Yes No
   If yes, how long ago? _____
2. Has your child ever had an unpleasant dental experience? Yes No
   If yes, please explain: _____
3. Have there been any injuries to your child's teeth or mouth? Yes
   If yes, please explain: _____
4. Does your child have a toothache or other urgent dental problem? Yes No
5. Was your child referred for?
   ◦ Specific Problem ◦ Routine Care
6. Is either parent nervous or anxious about their own dental treatment? Yes No
7. Has your child ever received a local anesthetic (freezing)? Yes No

DENTAL DISEASE PREVENTION

1. When does your child brush his/her teeth?
   ◦ very seldom ◦ morning ◦ after eating any food
   ◦ right after every meal ◦ before going to bed
2. Does your child use dental floss? Yes No
3. Does the tooth paste your child uses contain fluoride? Yes No
4. Do you ◦ assist your child with brushing? Yes No
   ◦ inspect for thoroughness of cleaning? Yes No
5. Have you ever been taught how to floss or brush? Yes No
6. Does your child eat between meals? Yes No
7. Does your child eat sweets, or drink soft drinks (*please check one)*
   ◦ less then once per week ◦ more then once but less than four times per week
   ◦ 4 – 7 times per week ◦ once per day ◦ more than once every day
8. How does your child receive fluoride?
   ◦ tooth paste ◦ fluoride drops or tablet ◦ water _____ ppm
9. How was your child fed as an infant? ◦ breast ◦ bottle
   Has your child stopped nursing? Yes No If yes, when _____
11. Has anyone in the family ever had orthodontic treatment (braces)? Yes No
12. Does/did your child ever have or do any of the following? *(check those that apply)*
   ◦ Bad breath ◦ Lip biting ◦ Bottle in bed ◦ Teeth grinding ◦ Tongue thrusting
   ◦ Drooling, ◦ Snoring ◦ Bed wetting ◦ Lisping ◦ Stuttering
   ◦ Gagging ◦ Cold sores ◦ Pacifier use ◦ Toothaches ◦ Mouth breathing
   ◦ Canker sores ◦ Stained teeth ◦ Thumb/finger sucking
13. Is there a family history of: *(check those that apply)*
   ◦ TMJ/Jaw joint problems ◦ Bad breath ◦ High rate of tooth decay ◦ Fear of dentistry
   ◦ Crooked teeth ◦ Gum disease ◦ Frequent headaches ◦ Missing or extra teeth

OFFICE USE ONLY

DENTAL HISTORY

Parent or Guardian Signature: _____ Date: _____ Dentist Signature: _____ Date: _____
M?D?Y M?D?Y