Child New Patient Questionnaire

Patient Name:_____ Birth Date:_____

At All Smiles Family Dentistry, we pride ourselves in comprehensive dental care. We have a series of questions we would like you to answer to help us understand your treatment goals.

Dental History

Please explain

Have you ever had any trauma to your teeth and/or jaws?.....Yes No_____
Have you had any unpleasant dental experiences?.....Yes No_____
Do you have any pain or areas of concern?.....Yes No_____
Do you have any problems eating food?.....Yes No _____
Have you had braces, retainers or a consultation with an orthodontist?.....Yes No _____
When was the last time you were at the dentist?_____ Who was your dentist?_____

Oral Hygiene

How often do you brush your teeth?_____
By self? With assistance? _____
Do you floss? _____ How often? _____
Do you use a toothpaste (training, fluoridated, etc.)? _____
What type of toothbrush do you use (handled, finger, powered, etc.) ?_____

Oral Habits

Please circle the following oral habits you have

Thumb sucking Finger Sucking Pacifier Nail Biting None Other:_____

What do you use to drink (bottle, sippy cup, regular cup, etc.)?_____

Please circle the following beverages you have on a weekly basis (all that apply)

Juice Milk Chocolate Milk Water Soda Sports Drink Other:_____

Please list the usual snacks you have between meals

_____

Why did you choose to come to our office?

Candy Buy Back Live Nearby School Visit Commercial Internet Other:_____

Referred by: _____
(patient name)

Is there anything else you would like us to know about your dental health that we did not cover in the above questions?_____

_____

_____