DENTAL HISTORY- MINOR

NAME:____
Last First M.I.

1. IS THIS YOUR CHILD'S FIRST VISIT TO THE DENTIST ___Y ___N

2. PURPOSE OF YOUR VISIT______________________________________

3. ARE YOU AWARE OF A PROBLEM___Y___N EXPLAIN ______________________

4. HOW LONG SINCE YOUR CHILD'S LAST DENTAL VISIT______________________

   WHAT WAS DONE AT THAT VISIT______________________________________

5. WHAT WAS YOUR PREVIOUS DENTIST'S NAME/PHONE ______________________

6. WHEN WERE YOUR CHILD'S TEETH LAST CLEANED__________________________

7. WERE ANY X-RAYS PREVIOUSLY TAKEN _____Y______N WHEN________________

8. HAVE YOU HAD COMPLICATIONS WITH PRIOR DENTAL CARE TAKE _____Y______N

   EXPLAIN____

9. DOES YOUR CHILD ____ EAT BETWEEN MEALS ___ EAT SWEETS/CANDY___ POP____ CHEW GUM

10. YOUR CHILD BRUSHES HIS/HER TEETH ___MORNING ____AFTER EATING/MEALS ____BEDTIME

11. DOES YOUR CHILD RECEIVE FLUORIDE _____Y____N _____ COMMUNITY WATER
    _____FLUORIDE DROPS OR TABLETS___FLUORIDE RINSE/ GEL

12. HAVE ANY CAVITIES BEEN NOTED IN THE PAST___Y____N

13. HAVE THERE BEEN ANY INJURIES TO YOUR CHILD'S TEETH (FALLS, BLOW, CHIPS) ____Y ___N

14. WERE ANY BABY TEETH EXTRACTED___Y___N

15. HAS ANYONE IN THE FAMILY INCLUDING PARENTS HAD ORTHODONTICS ____Y___N

16. HAS YOUR CHILD EVER RECEIVED A LOCAL ANESTHETIC____Y ____N

17. HAS YOUR CHILD EVER HAD OCCLUSAL SEALANTS____Y____N

18. DOES YOUR CHILD THINK THERE IS ANYTHING WRONG WITH HIS/HER TEETH ____Y____N

    EXPLAIN____

19. WHOM MAY WE THANK FOR REFERRING YOU TO OUR PRACTICE? PLEASE CIRCLE:

    ANOTHER PATIENT DAILY REGISTER ONLINE AD CHAMBER of COMMERCE NEWSPAPER

    ONLINE SEARCH VERIZON PHONE BOOK YELLOW BOOK COLUMBIA CTY PHONEBOOK

    NAME OF PERSON REFERRING YOU ______________________________

Parent Signature: ______________________________________