Clear Form

Drs. Love & Miller, P.C.

Child's Dental History and Habits

Child's Name		**Nickname**	
Today's Date		**Birth Date**	
Patient Account No.		**Medical Alert**	

Welcome! *So that we may provide you with the best possible care please complete the dental history and medical history forms. All information is completely confidential.*

1. What is the reason for your visit today? _____

_____

2. What was done at your child's last dental visit? _____

_____

Date of last dental visit _____ Last dental cleaning _____ Last x-rays _____

Your child's previous dentist name _____ Phone _____

Address _____ City _____ State _____ Zip _____

How often does your child brush? _____ Floss? _____ Do you assist? ☐ Yes ☐ No

Is your child's water fluoridated? ☐ Yes ☐ No

Does your child take fluoride supplements? ☐ Yes ☐ No

3. Does your child have any dental problems now? ☐ Yes ☐ No

If yes, please describe: _____

4. Has your child had difficulty with previous dental visits? ☐ Yes ☐ No

If yes, please describe: _____

5. Has your child complained about dental problems? ☐ Yes ☐ No

If yes, please describe: _____

6. Has your child ever worn orthodontic appliances? ☐ Yes ☐ No

If yes, please describe: _____

7. Are your child's teeth sensitive to:

Hot or Cold ☐ Yes ☐ No | Sweets ☐ Yes ☐ No | Biting or Chewing ☐ Yes ☐ No

8. Does your child engage in any of the following?

Sucking thumb or fingers	☐ Yes ☐ No	Chewing or biting fingernails	☐ Yes ☐ No
Biting or sucking lips or cheeks	☐ Yes ☐ No	Chewing hard objects (e.g., pencils)	☐ Yes ☐ No
Grinding teeth	☐ Yes ☐ No	Clenching jaw	☐ Yes ☐ No
Mouth breathing	☐ Yes ☐ No	Nursing bottle or pacifier habits	☐ Yes ☐ No

9. Do your child's gums bleed or hurt? ☐ Yes ☐ No

10. Does your child have any pain or tenderness in the jaw joint, ear side or face? ☐ Yes ☐ No

11. Do you have any special concerns about your child's dental health? ☐ Yes ☐ No

If yes, please describe: _____

_____

_____