Patient Name	Nickname	Age
Parent or Guardian Name	Relationship to Patient	

CHILD/ADOLESCENT DENTAL HISTORY To be completed by parent or guardian for patients 15 years and younger.

Does your child have a history of any of the following?

▢ Inherited dental characteristics	▢ Bleeding gums	▢ Toothache
▢ Sucking habit after 1 year of age	▢ Cavities/decayed teeth	▢ Injury to teeth, mouth or jaws
▢ Excessive gagging	▢ Bad breath	▢ Mouth sores or fever blisters

Please explain:

What is the **reason for your child's visit**?
▢ Check-up/Cleaning ▢ Filling(s)/Crown(s) ▢ Pain/Discomfort (if so, *where*?) ▢ Other:

Please provide details:

How often does your child **brush** his/her teeth?
▢ 1x/day ▢ 2x/day ▢ 3x/day ▢ My child does not brush ▢ Other:

How often does your child **floss** his/her teeth?
▢ Never ▢ Occasionally ▢ Daily ▢ Other:

How do you expect your child will **respond to dental treatment**?
▢ Very well ▢ Fairly well ▢ Somewhat poorly ▢ Very poorly ▢ Other:

Please use an "X" to mark your answers to the following questions.	Yes	No
Does someone help your child **brush**?	▢	▢
Does someone help your child **floss**?	▢	▢
Does your child participate in any **contact sports or similar activities** (skiing, motorcycles, etc)?	▢	▢
If yes, please explain:		
Has your child been **examined or treated by another dentist**?	▢	▢
Has your child ever had **orthodontic treatment** (braces, spacers, or other appliances)?	▢	▢
Has your child ever had a **difficult dental appointment**?	▢	▢
If yes, please explain:		
Does your child have a **speech, cognitive, or emotional difference** that may impact treatment?	▢	▢
If yes, please explain:		
Is there **anything else we should know** before treating your child?	▢	▢
If yes, please explain:		

Please use this space to provide any additional information you believe to be relevant.

To the best of my knowledge, the questions on this form have been accurately answered.

Signature of Patient or Responsible Party _____ Date _____

Relationship to the patient _____ Name if not the patient _____