

New Patient Dental History

Today's Date: _____

Child's Name: _____ Nick Name: _____ DOB _____ Age _____ M/F

GENERAL INFORMATION

You are referred by _____

Reason(s) for today's visit: _____

Past dental history: Today is the first visit to a dentist's office? _____ Yes _____ No

When was the last visit? _____ Who was the doctor? _____

What was done in the last visit? _____

Did he / she do well with the doctor? _____

DENTAL INFORMATION

Past dental history:

Yes	No		Yes	No		Yes	No	
_____	_____	Cavity	_____	_____	Teeth clean	_____	_____	Tooth extraction
_____	_____	Toothache	_____	_____	Dental X-ray	_____	_____	Prolonged bleeding after extraction
_____	_____	Gum swelling	_____	_____	Local anesthesia	_____	_____	Braces (Orthodontic treatment)
_____	_____	Injury to teeth / face	_____	_____	Filling(s)	_____	_____	Others

Mouth habits: Sucking finger / thumb _____ Pacifier _____ Breathing through mouth most of the time _____

Oral Hygiene: Has brushing been easy at home? _____ How often and when? _____

Use toothpaste with fluoride? _____ Floss? _____ Adult assisting? _____

Fluoride supplement? _____

Diet habit: (Sugary or Starchy) Snacks more than 3 / day? _____ Sips on juice frequently? _____ Sips on soft drinks frequently? _____

Infant / toddler: Bottle fed now? _____ Baby bottle at bedtime? _____ Breast fed now? _____ Breast fed at bedtime? _____

Comments: _____

