Cheryl M. Lee, DDS, MS **Pediatric & Adolescent Dentistry**
1174 Castro Street, Suite 150, Mountain View, CA 94040 **Tel: (650) 965-8688** **Fax: (650) 965-7988**

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:____

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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 _____

Oral Hygiene: Has brushing teeth been easy at home? ___________ How often and when? _______

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

Fluoride supplement? ____

Diet habit: (Sugary/Starchy) Snacks more than 3 / day? _______ Juices / sport drinks / soft drinks frequently?________________

Infant / toddler: Bottle fed now? ________Baby bottle at bedtime?______ Breast fed now? ________ Breast fed at bedtime?____

Comments: ____

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