



The Center for Oral Health

Dental History – Child

Date of last dental visit _____ For what service? _____

Dentist name _____ Phone Number _____

Address _____

Has your child complained about dental problems? Yes No

Explain _____

Unhappy dental experiences? Yes No Explain _____

Injuries to the mouth-teeth-head? Yes No Explain _____

Mouth habits

Thumb or finger sucking - Yes No

Mouth Breathing- Yes No

Nail Biting - Yes No

Lost Teeth - Yes No

Orthodontic Evaluation or Orthodontic Treatment (Braces) - Yes No

How often does your child brush their teeth? _____

Do you assist with your child's brushing? Yes No Is floss used? Yes No

Do you have city water? Yes No

Child's attitude toward their teeth/dentistry? _____