DENTAL HISTORY

What is the reason for today's visit?_____ Is this your child's first visit?_____

If no, name of previous dentist_____ Date of recent x-rays if taken_____

Does your child...

Brush Daily____Yes____No Floss Daily_____Yes_____No

Snack frequently____Yes____No If yes, what snack_____

Drink soda or juice_____Yes_____No If yes, how often_____

Receive flouride in any form_____Yes____No If yes, what form_____

_____

Have any of the following habits: Grinding of teeth____Yes___No Nail biting_____Yes_____No

Thumb/finger sucking_____Yes_____No Mouth Breathing_____Yes_____No Pacifier_____Yes_____No

Bottle when sleeping_____Yes_____No If yes, what beverage_____

When was nursing/bottle discontinued_____

Have your child's teeth, mouth, and/or head ever been injured?_____Yes_____No Date/Age_____

Describe injury_____

Which teeth were injured?_____ Was treatment provided?_____Yes_____No

If yes, describe_____

Has your child seen an orthodontist____Yes_____No If yes, Orthodontist name_____

Is your child currently in braces_____Yes_____No If yes, date started_____Phase_____I_____II

Is there anything else you would like to tell us regarding your child's dental health_____

_____

I affirm that the medical and dental information I have given is correct to the best of my knowledge. The above information will be held in the strictest confidence. I understand that it is my responsibility to inform Pediatric Dentistry of Newnan's dental staff of any personal or health information changes. I further understand that this consent will remain in effect until such time that I choose it to be terminated.

_____ _____

Parent/Guardian Name (Printed) Parent/Guardian Name (Signature)

_____ _____

Date Relationship to Patient **(Over)**