Johnson DENTAL

HEALTHY SMILES.
EXCEPTIONAL CARE.
EVERY DAY.

Child Dental History

Patient Name: _____

Date of birth: _____

Dental History

What is the reason for today's visit?_____

Is this your child's first visit to the dentist? ☐ Yes ☐ No

If no, date of last visit:_____ Date of last dental x-rays:_____

Was it a good experience? ☐ Yes ☐ No

Name of previous dentist:_____ Phone:_____

How would you describe your child? Relaxed Shy Outgoing Inquisitive Frightened Apprehensive

Oral hygiene habits

☐ Yes ☐ No Does your child brush daily? # of times per day:_____

☐ Yes ☐ No Does an adult assist with brushing?

☐ Yes ☐ No Does your child floss? # of times per week:_____

☐ Yes ☐ No Does an adult assist with flossing?

☐ Yes ☐ No Does your child receive fluoride in any of the following forms?

☐ Water supply ☐ Dentist ☐ Toothpaste ☐ Vitamins ☐ Tablets/drops ☐ Other_____

Check if your child has or has had any of the following mouth habits or conditions:

☐ Bad breath	☐ Fingernail biting	☐ Pacifier use	☐ Mouth breathing
☐ Bleeding gums	☐ Finger sucking	☐ Loose teeth or broken fillings	☐ Jaw pain or tenderness
☐ Blisters on lips	☐ Thumbsucking	☐ Gums swollen or tender mouth	☐ Sensitivity to (please circle)
☐ Dry mouth	☐ Lip sucking	☐ Grinding teeth	Cold / Hot / Sweets

Diet

☐ Yes ☐ No Does your child need a bottle or something to drink to go to sleep?

☐ Yes ☐ No Does your child wake up at night and eat or drink?

☐ Yes ☐ No Do you give your child something to eat or drink after brushing their teeth at night?

_____ How many snacks does your child eat each day? (Juice alone counts as a snack.)

_____ How much soda does your child drink each day?

☐ Yes ☐ No Does your child drink any beverage from a cup / sippy cup / bottle throughout the day?