Silverdale Dental Center
For Kids

## PATIENT DENTAL HISTORY

Patient Name: _____ Date: _____

1. What are you or your child's primary dental concern? _____
2. Please describe your child's general dental health (please circle) ❑**EXCELLENT** ❑**GOOD** ❑**FAIR** ❑**POOR**
3. Do you think your child has decay? ❑**YES** ❑**NO**
4. Is this your child's first visit to the dentist? ❑**YES** ❑**NO**
   If **NO** date of last visit? _____
   Former Dentist: _____
   Name City/State Phone
5. Were x-rays taken at the last visit? ❑**YES** ❑**NO**
6. Is your child apprehensive about the dentist? ❑**YES** ❑**NO**
7. Has your child had dental treatment before? ❑**YES** ❑**NO**
8. Has your child had sealants placed on any of their molars? ❑**YES** ❑**NO**
9. Have you or your child ever had an usual reaction or problem with dental anesthetic or treatment ❑**YES** ❑**NO**
   If **YES** please explain:_____
10. Has your child had any injuries to the mouth, teeth or face? ❑**YES** ❑**NO**
    If **YES** please explain: _____
11. How often does your child brush? _____Do you assist? ❑**YES** ❑**NO**
12. How often does your child floss? _____ Do you assist? ❑**YES** ❑**NO**
13. Do your child's gums bleed while brushing and/or flossing? ❑**YES** ❑**NO**
14. Has your child ever complained of tooth or gum pain? ❑**YES** ❑**NO**
    If **YES** please explain:_____
15. Does your child use fluoride supplements or fluoridated toothpaste? ❑**YES** ❑**NO**
    If **YES** please list:_____
16. Is your child drinking fluoridated water? ❑**YES** ❑**NO**
17. Please circle any of the following habits? ❑**Lip Sucking/Biting** ❑**Thumb Sucking** ❑**Nail Biting** ❑**Pacifier** ❑**Nursing/Bottle**
    Until what age did your child nurse? _____
18. Are you and/or your child happy with their smile? ❑**YES** ❑**NO**
19. Is your child missing any teeth? ❑**YES** ❑**NO** Please explain:_____
20. Has your child ever complained of sensitivity to hot, cold, sweets, or pressure? ❑**YES** ❑**NO**
    If **YES** please explain:_____
21. Does your child have a high sugar diet? (Soda, candy, fruit snacks, etc.) ❑**YES** ❑**NO**
    If **YES** please explain:_____
22. Do you hear your child clenching or grinding his or her teeth? ❑**YES** ❑**NO**
    If **YES** please explain:_____
23. Does your child have clicking, popping or jaw discomfort (TMJ)? ❑**YES** ❑**NO**
    If **YES** please explain:_____
24. Has your child ever had any slow healing sores in the mouth? ❑**YES** ❑**NO**
    If **YES** please explain: _____
25. Check any of the following concerns you have about your child's mouth, teeth or gums:

| | | | |
|---|---|---|---|
| ❑ Bad Breath | ❑Spaces | ❑Periodontitis | ❑Discolored Fillings |
| ❑ Bad Taste | ❑Infection | ❑Loose Teeth | ❑Gag Easily |
| ❑ Missing Teeth | ❑Swollen Gums | ❑Shifting Teeth | ❑Crooked Teeth |
| ❑ Broken Teeth | ❑Red Gums | ❑Appearance | ❑Baby Bottle Rot |
| ❑ Old Fillings | ❑Bleeding Gums | ❑Bad Bite | ❑Other_____ |
| ❑ Broken Fillings | ❑Gingivitis | ❑Dark Teeth | |