EASTSHORE PEDIATRIC DENTAL GROUP
TERI L. KIM, DDS THEA S. DOSANJH, DDS

Dental History

Child's name: _____

(Y) (N) Is this your child's first dental visit? If no, previous dentist: _____Phone_____

Date of last dental exam: _____ How was the experience?_____ (Y) (N) Were xrays taken?

What is your child's attitude toward going to the dentist? _____

If you have other children, how has their experience been at the dentist?_____

(Y) (N) Does your child complain of dental pain? If yes, explain: _____

(Y) (N) Has your child ever had braces or any orthodontic care? If yes, where and when? _____

(Y) (N) Is there a family history of missing/extra teeth, or gum disease? _____

(Y) (N) Do you, as a parent, have anxiety regarding your child's visit? If yes, please explain: _____

_____

(Y) (N) Does your child have any oral habits? (Circle): thumb/finger sucking pacifier nail biting Other:_____

(Y) (N) Has your child ever had an injury to their mouth, face, or teeth? If yes, explain: _____

(N) (Y) If your child plays contact sports (basketball, hockey, soccer, football, etc), does he/she wear a mouthguard?

(Y) (N) Do you or another adult assist your child with brushing and flossing?

(Y) (N) Is your child using a toothpaste with fluoride?

(Y) (N) Does your child take fluoride supplements?

How often does your child brush their teeth? _____ How often does your child floss? _____

Please circle the following that apply to your child:

breastfeeds bottle feeds sippy/straw cup sucks citrus fruit frequent snacker soda/juice frequent candy

tooth grinding snoring mouth breathing lip sucking

Please let us know anything that can help us make this visit a positive experience for your child: _____

_____

_____

_____ _____

Signature Date