

# Dental History

Child's Name: \_\_\_\_\_ Date: \_\_\_\_\_

Date of last cleaning? \_\_\_\_\_ Date of last x-rays? \_\_\_\_\_

Any known dental problems or concerns at this time?  
\_\_\_\_\_

## Eating Habits

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

Does he or she wake up at night and eat or drink?  Yes  No

How many snacks does your child eat each day? (juice alone counts as a snack)? \_\_\_\_\_

How much *soda* does your child drink each day? \_\_\_\_\_

Does he or she drink any beverage from a cup / sippy cup / bottle throughout the day?  Yes  No

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

## Fluoride

Do you have city or well water? \_\_\_\_\_

Do you have any water filtration systems at home or drink bottled water regularly?  Yes  No

## Brushing

Does he/she brush teeth daily?  Yes  No

Does he/she use floss every day?  Yes  No

Does he/she have help brushing their teeth?  Yes  No

## Teeth

Any mouth habits – thumb sucking, nail biting, mouth breathing, pacifier, sleeping with bottle?  Yes  No

Has he or she ever fallen and injured the front or back teeth?  Yes  No