DENTAL HISTORY

1.Why are you seeking dental care?_____

2. Do you have a particular reason for selecting us? ☐ No ☐ Yes If yes, why?_____

3. Has your child ever been to the dentist? ☐ No ☐ Yes If yes, when was the last visit?_____

4. Were you dissatisfied with your child's care? ☐ No ☐ Yes If yes, why?_____

5. Have your child's teeth and/or mouth been injured in the past? ☐ No ☐ Yes If yes, please describe nature of injury? Age of child? Which teeth/area of mouth?_____

6. Does you child need a mouth protector for contact sports? ☐ No ☐ Yes

7. Does your child have any of the following habits? Please check which one(s).

☐ Lip biting/sucking ☐ Nail biting ☐ Finger, thumb, blanket sucking ☐ Tongue thrusting

☐ Constant mouth breathing ☐ Cheek biting ☐ Jaw click/pain ☐ Teeth grinding/clenching

HOME DENTAL CARE

1. What is the source of your current drinking water supply? ☐ City ☐ Home well ☐ Don't know

2. Has your child received fluoride treatments in a dental office? ☐ No ☐ Yes

3. Has your child received prescribed or over-the-counter fluoride drops, tablets, or rinses? ☐ No ☐ Yes If yes, how long? And when? _____

4. Does your child brush his/her own teeth? ☐ No ☐ Yes If yes, how frequently? What brand?_____

_____If no, does someone other than your child brush his/her teeth?

☐ No ☐ Yes If yes, how frequently? What brand?_____

5. Does your child floss his/her teeth? ☐ No ☐ Yes If no, does someone other than your child floss his/her teeth? ☐ No ☐ Yes

6. Does your child eat between-meal snacks? ☐ No ☐ Yes If yes, how frequently during the average day? And List some of your child's favorite snacks:_____

SOCIAL/BEHAVIORAL HISTORY

1. How do you think your child has reacted to past dental/medical care?

☐ Very good ☐ Moderately good ☐ Moderately poor ☐ Very Poor

2. How do you think your child would react to our clinic?

☐ Very good ☐ Moderately good ☐ Moderately poor ☐ Very Poor

3. How would you rate you own anxiety/nervousness at the prospect of your child receiving dental care?

☐ Very good ☐ Moderately good ☐ Moderately poor ☐ Very Poor

4. Does your child believe there is anything wrong with their teeth? ☐ No ☐ Yes

5. Has your child been aware of anyone who has had an unpleasant dental experience? ☐ No ☐ Yes

6. Which of the following best describes your child? ☐ Advanced ☐ Normal ☐ Slow

7. Please check all words, which best describe your child: ☐ Healthy ☐ Compulsive ☐ Spoiled ☐ Sickly

☐ Suspicious ☐ Temper tantrums ☐ Moody ☐ Talkative ☐ High-strung ☐ Shy ☐ Defiant

☐ Active ☐ Friendly ☐ Cooperative ☐ Fearful ☐ Calm

8. Does your child have any hobbies or special interests? Please List:_____

9. Does your child have a(ny) pet(s)? If yes, type of pet(s) and their name(s):_____

10. Are there are other children in your family? If yes, plese list their names and ages: _____

_____

SUPPLEMENTAL ORTHODONTIC HISTORY

1. What is the reason for seeking orthodontic care?_____

2. Does anyone else in the family have a similar orthodontic condition? ☐ No ☐ Yes If yes, who?_____

3. Has anyone in the family received orthodontic care? ☐ No ☐ Yes If yes, who?_____

4. What type of orthodontic care interests you?

☐ Minor correction ☐ Comprehensive treatment ☐ Consultation/recommendation only

5. How well do you think the patient will react to orthodontic treatment? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

THANK YOU FOR BEING SO COOPERATIVE IN ANSWERING THE ABOVE QUESTIONS. ANY ADDITIONAL INFORMATION WHICH WOULD ALLOW US TO BETTER TREAT YOUR CHILD PLEASE LIST ON THE BACK. WE LOOK FORWARD TO PROVIDING THE HIGHEST DENTAL CARE FOR YOUR CHILD.