New Patient Medical and Dental History

Patient Name

First Name Last Name

Patient Date of Birth

Month Day Year

Name

First Name Last Name

I certify that the above information is correct:

- ○ Yes
- ○ No

Family Dental History

Please select any that apply:

- ☐ Parent's or Caregivers with history of frequent cavities
- ☐ Parent's or Caregivers with history of periodontal disease
- ☐ Siblings with history of cavities
- ☐ Siblings with history of dental care with sedation

Child's Dental History

Please select

- ☐ First dental visit
- ☐ Child has seen a dentist before

If not first visit, who was the dentist and when was the visit?

Oral Habits: please check those that apply

- ☐ Sucks thumb or fingers
- ☐ Used pacifier
- ☐ Chews often on toys or clothing

Home Care: Are teeth brushed at home?

- ☐ Yes, by parent only
- ☐ Yes, by child themselves
- ☐ Yes, parentand child together
- ☐ Teeth cleaned with washcloth only
- ☐ No brushing or cleaning

Home Care: Fluoride usage?

- ☐ Fluoride toothpaste used
- ☐ Non-fluoride toothpaste used
- ☐ Fluoride rinse used
- ☐ Other rinse or medicament used

Infant Feeding (skip if child over age 3)

- ☐ Current breastfeeding
- ☐ Milk or juice at night for sleeping

Beverage History: In a typical day what does your child drink?

- ☐ water
- ☐ milk (only at meals)
- ☐ milk (in a cup or bottle throughout day)

- ☐ juice
- ☐ sweetened tea
- ☐ sugar-free beverage (Mio drops, sparkling water etc.)
- ☐ sodas
- ☐ other beverages

Diet History: In a typical day what does your child eat?

- ☐ Crackers or granola bars
- ☐ Cheese or yogurt
- ☐ Fruit pouches
- ☐ Fruit snacks or dried fruit
- ☐ Fresh fruits or vegetables
- ☐ Cookies or baked treats
- ☐ Candy, suckers or sweets
- ☐ Mac and Cheese, noodles, bread products

Daily Medicines?

- ☐ Gummy vitamin
- ☐ Chewable "Flintstones" style vitamin

What are your concerns today?

- ☐ Oral hygiene
- ☐ Cavities
- ☐ Bad breath
- ☐ Bleeding gums
- ☐ Tooth Pain
- ☐ Gum or face swelling
- ☐ Crowding or tooth position

Other dental concern: