Patient Name: ______________________

Patient DOB: ______________________

New Patient Dental History Form - Child

Is this the child's first visit to the dentist? ☐ Yes ☐ No

If not the first,when were they last seen by a dentist?

____

Is there a previous dental office Edina Dental Care should contact to request x-rays and records? ☐ Yes ☐ No

If yes, please provide the name of the office and their telephone number:

____

Did their previous dentist advise any treatment that has not been completed? ☐ Yes ☐ No / Not Applicable

If yes, please explain:

____

Has the child expressed any fear or concerns over visit the dentist? ☐ Yes ☐ No

If yes, please explain:

____

Has the child had any orthodontic treatment? ☐ Yes ☐ No

If yes, please provide the name of their orthodontist:

____

Please check all treatments that the child has had:

- ☐ Athletic mouth guard or sports guard
- ☐ Removeable orthodontic device such as a retainer or expander
- ☐ Serious injury to mouth or head
- ☐ Teeth removed
- ☐ None of the above

Have you or the child noticed any:

- ☐ Clenching or grinding their teeth while awake or asleep
- ☐ Clicking, popping, or locking of the jaw
- ☐ Difficulty in opening or closing their mouth
- ☐ Sensitive teeth to cold, hot, sweets, biting, or chewing
- ☐ Jaw pain (joint, ear, side of face)
- ☐ Tired jaw, especially in the morning
- ☐ Pain in head, neck, shoulders, or back
- ☐ None of the above

How many times does the child brush their teeth? ______________________

When does the brushing occur? ______________________

Does the child use any other dental aids like floss? ______________________

Is there anything else we should be aware of regarding the child's dental health or their appointment today?

____

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