HAMILTON CO. PEDIATRIC DENTISTRY

What is your primary concern about your child's oral health? _____

How would you describe your child's oral health?.....	☐ Excellent	☐ Good	☐ Fair	☐ Poor
How would you describe *your* oral health?.....	☐ Excellent	☐ Good	☐ Fair	☐ Poor
How would you describe your family's oral heath?.....	☐ Excellent	☐ Good	☐ Fair	☐ Poor
How will your child respond to dental treatment?.....	☐ Excellent	☐ Good	☐ Fair	☐ Poor

- or- ☐ Unsure of my child's potential behavior

Does your child have any of the following? If yes, please describe.

Inherited dental anomalies……..	☐ Yes	☐ No	_____
Mouth sores or fever blisters……..	☐ Yes	☐ No	_____
Bad breath……..	☐ Yes	☐ No	_____
Bleeding gums……..	☐ Yes	☐ No	_____
Cavities/tooth decay……..	☐ Yes	☐ No	_____
Toothache……..	☐ Yes	☐ No	_____
Injury to teeth or mouth……..	☐ Yes	☐ No	_____
Clenching or grinding……..	☐ Yes	☐ No	_____
Jaw joint problems (popping, pain, etc)....	☐ Yes	☐ No	_____
Excessive gagging……..	☐ Yes	☐ No	_____
Sucking habit (fingers, pacifier, etc)……..	☐ Yes	☐ No	_____

Please answer the following questions concerning your child's oral hygiene.

How often does your child brush his/her teeth? _____ times per _____

Does someone help?.....☐ Yes ☐ No

How often does your child floss his/her teeth? _____ time per _____

Does someone help?.....☐ Yes ☐ No

What type of toothbrush does your child use? _____

What type of toothpaste does your child use? _____

What type of water does your child drink (city, well, bottled, filtered)? _____

Does your child use fluoride rinse, gel, drops, or tablets?..... ☐ Yes ☐ No

If yes, please describe: _____

Please answer the following questions concerning your child's diet.

Does your child regularly eat 3 meals a day?.....	☐ Yes	☐ No	
Is your child on a restricted diet?.....	☐ Yes	☐ No	Describe: _____
Is your child a picky eater?.....	☐ Yes	☐ No	Describe: _____
Does your child have a diet high in sugar?.....	☐ Yes	☐ No	Describe: _____
Does you child have a diet high in carbohydrates?	☐ Yes	☐ No	Describe: _____

How frequently does you child:

Eat candy, cookies, cake, or processed desserts?.....	☐ Rarely	☐ 1-2 times/day	☐ 3/+ times day
Drink soda, energy drinks, or carbonated drinks?.....	☐ Rarely	☐ 1-2 times/day	☐ 3/+ times day
Drink juice, fruit punch, or box drinks?.....	☐ Rarely	☐ 1-2 times/day	☐ 3/+ times day
Chew gum or mint?.....	☐ Rarely	☐ 1-2 times/day	☐ 3/+ times day
Snack between meals?.....	☐ Rarely	☐ 1-2 times/day	☐ 3/+ times day

Please answer the following questions:

Does your child participate in sports?.....	☐ Yes	☐ No	List: _____
Does your child wear a mouth guard?.....	☐ Yes	☐ No	Type: _____
Has your child been treated by another dentists?...	☐ Yes	☐ No	Name: _____

If yes, date of last visit: _____ Reason for last visit: _____

Were x-rays taken?.....☐ Yes ☐ No

Any difficulty with dental treatment?.....☐ Yes ☐ No

If yes, please describe: _____

Any additional concerns or special requests? _____