Westbrook Dental Centre
Child Dental History

1. Has your child had previous dental care? ☐ Yes ☑ No

   When?

2. Has she or he ever had an unpleasant experience associated with dental treatment? ☐ Yes ☑ No

   Specify

3. Has your child ever had an accident or surgery about the mouth? ☐ Yes ☑ No

   Specify

4. Is there a family history of any of the following? ☐ Yes ☑ No

   ☐ High decay rate ☐ Missing teeth ☐ Spaced teeth
   ☐ Tooth deformity ☐ Extra teeth ☐ Gum disease
   ☐ Crooked or crowded teeth

   If "Yes" to any of the above, please specify:

5. Is there a family history of any of the following? ☐ Yes ☑ No

   ☐ Thumbsucking ☐ Nail biting ☐ Lip biting
   ☐ Mouth breathing ☐ Tongue thrusting ☐ Fingersucking
   ☐ Teeth grinding

   If "Yes" to any of the above, please specify:

6. How often does your child brush his or her teeth?
7. Do you supervise your child while she or he is toothbrushing? ☐ Yes ☑ No
8. Has your child ever received oral hygiene or toothbrushing instructions from a dentist or dental hygienist? ☐ Yes ☑ No
9. Has your child ever received flouride supplements in the diet or water supply? ☐ Yes ☑ No
10. Were his or her teeth ever treated with decay preventing topical fluorides? ☐ Yes ☑ No
11. Are you interested in a caries (dental decay) preventing program for this child? ☐ Yes ☑ No

I authorize Westbrook Dental Centre to contact me in regards to dental treatment.

I certify that the above medical and dental information is true for the child and complete to the best of my knowledge.

I Authorize the dentist to contact my child's physician if required.

Child's Name:

Print

Parent/Guardian Signature: _____

Date: 9-Nov-2018

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