Your Child's Dental History

What is the reason for your visit today? _____

Is this their first dental cleaning/check-up? Yes No

Does your child have any fear of dental visits? 1 2 3 4 5 6 7 8 9 10
(No Anxiety) (Very Anxious)

How do you consider your child's current dental health? (Circle One) Good Fair Poor

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Is your child an **INDEPENDENT BRUSHER?** Yes No

How many times a day does your child brush? _____/day Floss? _____/week

Does your child use a power toothbrush? Yes No

Your Child's Smile Assessment

Are there any immediate concerns that you have about your child's mouth?
(Circle All that Apply)

Crooked teeth Gaps in Teeth Shape of Teeth Color of Teeth

Growth and Development Trauma to teeth or mouth

Other: _____