Name___________________________ Nickname______________ Date_____________

CHILD'S DENTAL HISTORY

FIRST VISIT INFORMATION (Only new patients and their parent should complete section)

- ☐ This is my child's very first dental visit.
- ☐ My child has a toothache.
- ☐ My child is concerned about today's visit.
- ☐ My child has had an accident involving the head, mouth or teeth.
- ☐ My child has had an unsatisfactory visit in the past.

DENTAL HEALTH (Please mark all that apply to your child)

- ☐ Dental x-rays were taken by my child's previous Dentist. Dr.______________________________
- ☐ My child was breast or bottle fed for more than one year
- ☐ My child slept with a baby bottle. (what was in the bottle? __________________________)
- ☐ My child sucks a thumb or fingers.
- ☐ My child uses a pacifier.
- ☐ My child grinds or clenches teeth.
- ☐ My child has had an injury to mouth or teeth.
- ☐ My child has a toothache.
- ☐ My child has bleeding gums.

My child's last dental exam, cleaning and fluoride treatment was on ______________________________.
My child's water source is mostly ☐ Well ☐ Public System ☐ Bottled or Distilled
My child: Brushes_____ times per day Flosses _____ times per day Uses fluoride rinse _____ times per day

Are there any other dental concerns you have about your child?
____
____

TREATMENT CONSENT FOR A MINOR BY PARENT OR LEGAL GUARDIAN

Dr. Andrew G. Gilfillan and his staff are authorized to provide dental treatment and utilize necessary radiographs, medications, anesthetics, mouth props and other techniques to permit quality care for,

Child's full name ____

The undersigned understands and agrees that all treatment records remain the property of this office and that the risks and benefits of all treatment will be explained.

______________________	______________	______________________
Parent or Legal Guardian	Date	Witness