## DENTAL HISTORY

What is your	main co	oncern about your child	d's dental health?	
Has your child	d been	to a dentist before?	Yes No	PETERS LANGUAGE FOR THE
			Date of last X-rays:	
Check Yes No ?	Has you Has you Has you Has you Has you Was you Did you Does you Do you Do you Did you Did you Do you Do you Did you Did you Do you Did you	our child experienced proper child be uncooperative our child experienced any our child inherited any fair child had any injury to our child had any clicking our child breast fed? When our child bottle fed? When our child use a pacifier? When our child suck a finger or the court child brush his//her our child use dental flost our child suck a finger or the court child use dental flost our child use dental flost our child's gums bleed when or your child ever get in	y complications following dental treatmer mily facial or dental characteristics? If ye to the teeth, jaws or face? If yes, explain. or pain in the jaw joints? If yes, explain. en stopped? when stopped? when stopped? chumb? when stopped?	ent? If so, explain.  nt? If so, explain.  s, explain.
Please check	if your	child has had problems	s with any of the following:	2.87%
Cavities		Color of teeth	☐ Teeth sensitive to hot or cold	☐ Bleeding Gums
☐ Tooth ache	es	☐ Gum Infection	☐ Teeth sensitive to sweets	☐ Appearance of teeth
☐ Teeth bumped		☐ Grinds teeth	Other dental problems	
— Explanation	s and	comments:		
in my child's m additional info PERSON COM	edical ormation	or dental status to the de a from my child's physici IG THIS FORM: Signatu	ve given are accurate. I understand it is entist, and I agree to do so. I give permitian regarading medical history needed to	ssion to the dentist to obtain o provide dental treatment.
Medical and Dental History reviewed by:				Date: