KOHLMEIER DENTAL LLC

DENTAL HISTORY (MINOR)

Patient Name: _____

DOB: _____

General Information

Who was your child's previous Dentist?	
Date of your child's last dental exam:	
Date of your child's last cleaning:	
What is the reason for your child's dental visit?	

Personal History

Has your child experienced any unfavorable reaction from previous dental care?	
Does your child suck a finger, thumb, or pacifier?	
Does your child have pain with chewing, yawning, or wide opening?	
Does your child go to bed with a bottle or sippy cup?	
Does your child snack frequently?	
Has your child had local anesthetic?	
Has your child been sedated for dental treatment?	
Have your child's teeth ever been injured?	
Does your child use fluoride toothpaste?	

Dental Problems

Please check if your child is having problems with any of the following	
Cavities	
Trauma	
Orthodontics	
Toothache	
Gum Infections	
Other	

Parent's signature: _____ Date: _____