Maria Aslani-Breit, D.D.S., P.L.L.C.
Pediatric Dentistry

Patient Name:_____ Date of Birth:____/____/_____
LAST FIRST MIDDLE

DENTAL HISTORY

	YES	NO
Is this your child's first visit to the dentist?	☐	☐
If no, what is the • Date of last dental visit _____ • Date of last X-rays _____		
Is your child having a problem now?	☐	☐
What is the reason of today's visit?		
Do you or does your child have any concerns about your child's dental health?	☐	☐
Has your child had any previous unfavorable dental or medical experiences?	☐	☐
Do you think your child will be upset by dental treatment?	☐	☐
Are you nervous about this appointment?	☐	☐
Has your child had toothaches in the past?	☐	☐
Has your child ever had injuries to teeth, mouth, or face?	☐	☐
Has your child ever had a problem with grinding/clenching his/her teeth?	☐	☐
Has your child ever complained about clicking his/her jaw?	☐	☐

PREVENTIVE ASSESMENT

	YES	NO
Does your child use a pacifier or suck a thumb or finger?	☐	☐
Does your child sleep with a bottle?	☐	☐
Is your child on a special diet?	☐	☐
Does your child brush his/her own teeth?	☐	☐
Does an adult help with brushing?	☐	☐
Does your child use floss?	☐	☐
Does your child's gum bleed when brushed?	☐	☐
Does your child use fluoridated toothpaste daily?	☐	☐
Is your water supply fluoridated?	☐	☐
Do you use bottled water, or a water filtration system?	☐	☐
Has your child used fluoride supplements?	☐	☐
If yes, please list:		
Does your child eat snacks high in sugar (candy, soda etc.)?	☐	☐
If yes, how often?		