CHANTILLY GREEN DENTAL CARE
13035-D Lee Jackson Memorial Hwy Fairfax, VA 22033
(O) 703-378-2466

YOUR CHILD'S DENTAL HISTORY AND HABITS

Welcome! *So that we may provide your child with the best possible care, please complete both sides of this dental/medical history form. All information is completely confidential. Please be sure to answer individual any "yes" or "no" questions.*

Name:	Nickname:	Date:

What is the reason for your visit today? ____

Your child's previous dentist's name: ________________________ Tele: _____________

Address: ____

Date of your child's last dental visit ______________, last dental cleaning ___________

How often does your child brush? ___________/ day, Floss? ____________/ day

Do you assist? *Yes/ No* , Is your child's water fluoridated? *Yes/ No*

Does your child take fluoride supplements? *Yes/ No*

Does your child have any dental problem now? *Yes/ No.* If yes, please describe:
____

Has your child had difficulty with previous dental visits? *Yes / No* . If yes, please describe:
____

Has your child complained about dental problems? *Yes/ No*. If yes, please describe: __

Your child ever worn orthodontic appliances? *Yes/ No*. When? ________________

Are any of your child's teeth sensitive to:

Hot/ Cold? *Yes/ No*	Sweets? *Yes / No*	Biting / Chewing? *Yes/No*

Does your child engage in:

Sucking thumb/ fingers? *Yes/ No*	Chewing or biting fingernails? *Yes/ No*
Biting or sucking lips/cheeks? *Yes/ No*	Chewing hard objects? *Yes/ No*
Grinding teeth? *Yes/ No*	Clenching jaw? *Yes/ No*
Mouth breathing? *Yes/ No*	Nursing bottle or pacifier habits? *Yes/No*

Does your child's gum bleed or hurt? *Yes/ No*

Does your child have any pain or tenderness in the jaw joint, ear, side of face? *Yes/ No*

Do you have any special concerns about your child's dental health? *Yes/ No*

If yes, please describe: ____