HORIZON
family dentistry
Grant & Joyner DDS, PA

Child Dental History

Date of Last Dental Visit _____
By Dr. _____
Do you have any Current Records (including x-rays) from another practice? Yes No Has your child complained about any dental problems?_____
_____ Any injuries or surgeries to mouth, teeth, head? Yes No If yes, please describe: _____
_____
_____ Does your child still take the bottle or sippy cup? _____
_____
Does your child brush daily? Yes/ No How Often?
_____
_____
Do you assist your child w/Brushing? Yes/No How Often?
_____
Is Dental Floss used?Yes No
Please check each box if your child has any of the following mouth habits
Thumb Sucking Mouth Breathing Pacifier Nail Biting Finger Sucking
Grinding Other _____
How does your child receive Fluoride?
Water Supply Dentist Toothpaste Vitamins Tablets None
Other:
_____
Reason for Today's Visit/Chief Concerns:
_____

I hereby certify that all of the above information is correct and true. Because the above-named child is a minor, it is necessary that a signed permission is obtained from a parent or guardian before any and/or all necessary dental treatment can be commenced. Furthermore, I will be responsible for any professional fees incurred for dental services for my child.

Signed _____Date _____
Relationship to Patient
_____

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