THE BEACH HOUSE
PEDIATRIC
DENTISTRY & ORTHODONTICS

Dental Questionnaire

Patient Name: _____ Age_____ Sex:____ Date of Birth: _____
Date of last dental exam:_____ Dentist's Name:_____

What is your primary concern about your child's oral health? _____

How would you describe your child's oral health?
Excellent Good Fair Poor

Is there a family history of cavities? Yes No

Does your child have a history of any of the following? If yes, please describe.

Inherited dental characteristics	Yes	No	_____
Mouth sores or fever blisters	Yes	No	_____
Bad breath	Yes	No	_____
Bleeding gums	Yes	No	_____
Cavities/ decayed teeth	Yes	No	_____
Toothache	Yes	No	_____
Injury to teeth or jaws	Yes	No	_____
Clinching or grinding teeth	Yes	No	_____
Jaw problems	Yes	No	_____
Excessive gagging	Yes	No	_____
Sucking habit after 12 mo old	Yes	No	_____
Finger, thumb, pacifier, other			_____
For how long?			_____

How often does your child brush his/ her teeth? _____
How often does your child floss his/ her teeth? _____
Does someone assist with brushing/ flossing? _____

Does your child take fluoride supplements?	Yes	No
Is your child on a special diet?	Yes	No
Does your child play sports?	Yes	No
Has your child ever had a difficult dental appointment?	Yes	No

Anything else we should know before treating your child? _____

_____ _____
Signature (Patient, Parent or Guardian) Date