Stewart Dental

Child's Dental History

Child's Name _____ Age _____Date _____

Date of last dental visit _____

What service did the child have done _____

Has child complained about dental problems _____

Any unhappy dental experiences _____

Any injuries to mouth – teeth or head _____

Any mouth habits – thumb sucking – nail biting – mouth breathing – nursing bottle habits – pacifier use etc. _____

How often does child brush _____Is dental floss used _____

Any other concerns:

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