**DENTAL HISTORY**

Name: [First, MI, Last]

Suffix: \_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth [mm/dd/yyyy]

Yes/No Has your child been to the dentist before?

If yes, please provide date of last x-rays \_\_\_\_\_\_\_\_\_\_\_\_\_

Yes/No Has your child had any unfavorable reaction or past traumatic experiences to

Dental treatment?

If yes, please explain here \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Any Oral Habits? Yes/No**

Yes/No Thumb Sucking

Yes/No Finger Sucking

Yes/No Nail Biting

Yes/No Mouth Breathing

Yes/No Pacifier

Yes/No Lip Sucking

Yes/No Grinding Teeth

Please indicate if you child has issues with any of the following?

Yes/No Cavities

Yes/No Trauma

Yes/No Orthodontics

Yes/No Toothache

Yes/No Gum Infections

Yes/No Jaw Sounds

Yes/No Sensitive Teeth

Yes/No Color of Teeth

Other Please describe \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Consent for Dental Treatment**

I authorize the rendering of diagnostic and treatment procedures including, but not limited to: fluoride, local anesthesia, and radiographs. I authorize the doctors and dental staff of Prime Pediatric Dentistry to provide services, that in their professional opinion, may be deemed necessary or beneficial. However, prior to rendering any definitive treatment, the proposed treatment plan will be presented and/or discussed with the parent or guardian.

I further understand that this consent will remain in effect until such time that I effectively choose to terminate consent for dental treatment.

Signature: \_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_