

**MINOR DEPENDENT DENTAL HISTORY**

Patient Name: \_\_\_\_\_ Nickname or Preferred Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Date: \_\_\_\_\_

1. Reason for initial visit: \_\_\_\_\_

2. Date of last dental exam: \_\_\_\_\_ Last cleaning: \_\_\_\_\_ Last x-rays: \_\_\_\_\_

3. Circle any of the following which this patient has had or has at present:

- |                  |                         |  |
|------------------|-------------------------|--|
| Toothache        | Orthodontic treatment   | Mouth breathing                        |
| Abscessed tooth  | Oral surgery            | Clenching or grinding teeth            |
| Cold sores       | Bleeding gums           | Fillings                               |
| Fever blisters   | Pain in jaw joints      | Pit & Fissure sealants When?           |
| Missing teeth    | Difficulty chewing      | Local Anesthetic (Novocaine/Xylocaine) |
| Extra teeth      | Injury to teeth         | Nitrous Oxide (laughing gas)           |
| Discolored teeth | Injury to jaws          | Fluoride treatments                    |
| Crowded teeth    | Thumb or finger sucking | Other:                                 |

Comments: \_\_\_\_\_

4. Is this patient fearful about dental treatment? ..... Yes No

If yes, please explain: \_\_\_\_\_

5. Has this patient ever had an upsetting experience in a dental office? ..... Yes No

If yes, please describe: \_\_\_\_\_

6. How do you think he/she will react to dental treatment? \_\_\_\_\_

7. Do we have your permission to administer Nitrous Oxide if needed? ..... Yes No

8. Is there any other information that would be helpful to us in treating this patient? ..... Yes No

Comments: \_\_\_\_\_

9. What school does this patient attend? \_\_\_\_\_

10. Names and ages of brothers and sisters: \_\_\_\_\_

11. Hobbies, interests, pets: \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_