DEXTER DENTAL STUDIO

Healthy Mouth. Healthy Body. Healthy Mind.

Child's Name____

Child's Age______________________ Caregiver's last dental visit___________________

Child's Birth Date_________________ Caregiver's Oral Health ☐ FAIR ☐ GOOD ☐ POOR

Health History	**YES**	**NO**
Did mother have any problems during pregnancy?	☐	☐
Was your child premature?	☐	☐
Was your child's birth weight low?	☐	☐
Were there any complications at birth?	☐	☐
Has your infant been ill/have any disabilities?	☐	☐
Does your child experience frequent ear aches or colds?	☐	☐
Does your child have their tonsils/adenoids?	☐	☐
Does your child snore or breathe heavily during sleep?	☐	☐
Does your child sleep with their mouth open?	☐	☐
Does your child appear to be a restless sleeper?	☐	☐
Does your child occasionally wet the bed?	☐	☐
Does your child have nightmare or night terrors?	☐	☐

Diet and Nutrition

Is/was your child breast-fed?	☐	☐
Any complications? ____		
Does your child sleep with a bottle or cup?	☐	☐
Does your child experience reflux?	☐	☐
Does your child drink from a cup?	☐	☐
Is your child on a special diet?	☐	☐
Is your child a picky eater?	☐	☐
Is your child a noisy or messy eater?	☐	☐
What does your child usually eat for a snack? ________________________________		

Fluoride

Do you have well or city water?____		
Do you use bottled water for your child?	☐	☐
Do you use a water filtration system?	☐	☐
Does your child take fluoride supplements?	☐	☐
If yes please list:____		
Do you use fluoridated toothpaste for your child?	☐	☐
Has your child's pediatrician applied fluoride to your child's teeth?	☐	☐

Oral Habits

Does or did your child use a pacifier?	☐	☐
Does your child suck a thumb or finger(s)?	☐	☐
Does your child put objects in their mouth?	☐	☐
Does your child grind teeth day or night?	☐	☐

Oral Trauma

Has your child had an oral/facial injury?	☐	☐

Oral Development

Child's age (in months) when first tooth erupted ___________		
Has your child experienced teething problems?	☐	☐
Have you noticed any oral problems in your child?	☐	☐

Does your child breathe through their mouth?	☐	☐

Oral Hygiene

Do you clean your child's teeth/gums?	☐	☐
Do you use a toothbrush to clean your child's teeth?	☐	☐
Do you use toothpaste to clean your child's teeth?	☐	☐

Learning and Development

Does your child have difficulty organizing tasks?	☐	☐
Does your child have difficulty listening when being spoken to?	☐	☐
Is your child easily distracted by extraneous stimuli?	☐	☐
Does your child have difficulty listening when being spoken to?	☐	☐
Does your child fidget with hands or feet or squirms in seat	☐	☐
Is your child sleepy during the day, or have difficulty waking up?	☐	☐
Has your child been diagnosed with ADD or ADHD	☐	☐
Does your child have difficulty with pronunciation?	☐	☐
Have you noticed any language delays in your child?	☐	☐

Additionally:

Has your child seen any of the following specialists? Please circle and explain the reason for referral.

Occupational Therapist
Physical Therapist
Speech Language Pathologist
Feeding- Swallowing Therapy
Applied Behavior Analysis Therapist
Dietician

Otolaryngologist/ENT
Allergist
Neurologist
Psychologist
Sleep Specialist

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Parent/Guardian Signature: ____ Date:_________________________

Parent/Guardian Name Printed: ____

Provider Intl:______