DENTAL HISTORY (CHILD 17 YEARS OR YOUNGER)

1. Are you having pain or discomfort from your mouth at this time?

   YES NO UNKNOWN WHERE?_____

2. Do you feel nervous about having dental treatment?

   YES NO

3. Have you ever had a bad experience in the dental office?

   YES NO UNKNOWN WHEN?_____

4. Do you brush your teeth at least twice daily?

   YES NO HOW OFTEN?_____

5. Do you use dental floss, a proxabrush or toothpicks?

   YES NO HOW OFTEN?_____

6. Have you ever had periodontal (gum) treatment?

   YES NO UNKNOWN WHEN?_____

7. When did you last have your teeth cleaned?

_____

8. How often do you have your teeth cleaned in a year?

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