Pediatric Dental History Form

Patient Information

Child's Name

Date of Birth

Age

Gender

Parent/Guardian Name

Phone Number

Medical History

Child's Physician

Physician Phone

Medical Conditions

Allergies

Does your child take any medications?

- Yes
- No

If yes, please list:

Dental History

Is this your child's first dental visit?

- ○ Yes
- ○ No

Previous Dentist

Date of Last Visit

Dental Concerns/Problems

Does your child have any of the following habits?

- ☐ Thumb/Finger Sucking
- ☐ Pacifier
- ☐ Nail Biting
- ☐ Tooth Grinding
- ☐ Others

If others, please specify:

Additional Information

Is there any additional information we should know?