General Information/Health History

Full name: _____ **DOB:** _____ **Date:** _____

DENTAL HISTORY

Has your child ever been to the dentist? Yes No If yes, Dentist Name _____ Date _____

Is there any history of injury to the teeth? Yes No If yes, Please describe_____

Which personality best describes your child Shy Easy to warm up Active Rambunctious

Do you think your child will cooperate for dental treatment? Yes No

What is the reason for your visit today? Check Up Tooth Ache Cavities Injury Consultation/Second Opinion

HEALTH HISTORY

Is your child currently under the care of a physician? - - -