



## **A WINNING SMILE DENTAL CENTER**

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### **Child's Dental History**

Patient's Name \_\_\_\_\_

Is this your child's first visit with a dentist (YES or NO)? \_\_\_\_\_ If NO, how long ago? \_\_\_\_\_

Name of previous dentist \_\_\_\_\_

What was done for your child at the last visit? \_\_\_\_\_

Date of your child's last full mouth set of x-rays \_\_\_\_\_

Is your child apprehensive about dental treatment? \_\_\_\_\_

Any unhappy dental experiences? \_\_\_\_\_

What is the reason for today's visit? \_\_\_\_\_

Any injuries to the mouth, teeth, or head? \_\_\_\_\_

Any unusual speech habits? \_\_\_\_\_

Any mouth habits- thumbsucking, nail biting, mouth breathing, nursing bottle habits, pacifier, etc? \_\_\_\_\_

How often does your child brush? \_\_\_\_\_

Do you assist with tooth brushing? \_\_\_\_\_

Is fluoride taken in any form? \_\_\_\_\_

Does your child floss? \_\_\_\_\_

About your child:

Are you happy with the appearance of your child's teeth? \_\_\_\_\_

Is your child's dental health poor? \_\_\_\_\_

Has your child had any professional oral hygiene instructions? \_\_\_\_\_

Are any of your child's teeth sensitive to hot, cold, or sweets? \_\_\_\_\_

Are you aware of your child clenching or grinding his or her teeth? \_\_\_\_\_

Has your child worn braces? \_\_\_\_\_

If so, name of the orthodontist \_\_\_\_\_

Describe your child: (circle one of each pair)

Shy	-	Talkative
Fearful	-	Confident
Restless	-	Patient
Reserved	-	Cooperative

Any other comments about your child \_\_\_\_\_

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