



The Little Smile Loft

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Please answer the following dental questions for yourself, or on behalf of your dependent if you are not the patient receiving care.

Dental History

Please answer the following questions about your child's dental history.

Do you have any of the following dental conditions?

- | | |
|--|--|
| ☐ Bad breath | ☐ Chew on one side of the mouth |
| ☐ Clench or grind teeth | ☐ Cigarette, pipe, or cigar smoking |
| ☐ Bleeding gums | ☐ Smokeless tobacco |
| ☐ Cavities/decayed teeth | ☐ Dry mouth |
| ☐ Excessive gagging | ☐ Food collection between teeth |
| ☐ Inherited dental characteristics | ☐ Growths or sore spots in your mouth |
| ☐ Injury to teeth, mouth, or jaws | ☐ Gums swollen, tender or bleeding |
| ☐ Jaw joint problems (popping, etc.) | ☐ Head, neck, jaw pain, or aches |
| ☐ Mouth sores or fever blisters | ☐ Lip or cheek biting |
| ☐ Sucking habit after one year of age | ☐ Loose teeth or broken fillings |
| ☐ Toothache | ☐ Mouth breathing |
| ☐ Blisters on lips or mouth | ☐ Sensitivity to pressure or irritants (cold, heat, sweets) |
| ☐ Burning sensation on tongue | |

Do you have any other dental conditions?

Former Dentist

Date of last dental visit

Date of last dental x-rays

How often do you floss per day?

- | | |
|-------------------------|-------------------------|
| ☐ 0 | ☐ 2 |
| ☐ 1 | ☐ 3 |

How often do you brush per day?

- | | |
|-------------------------|-------------------------|
| ☐ 0 | ☐ 2 |
| ☐ 1 | ☐ 3 |

Have you ever had an allergic reaction to local or general anesthetics?

☐ Yes ☐ No

Has your child ever had any difficult experiences in the dental setting?

☐ Yes ☐ No

Is there anything that we can do to make your child's visit as comfortable as possible?

☐ Yes ☐ No

I have read my child's dental history and confirm that it adequately reflects past and present conditions.

X _____

Date: _____