Kenneth L. Andow
DDS • PC
Cosmetic and family dentistry with a caring touch

Dental History (Child)

Name: _____ Date: _____

Reason for child's visit: _____

Is this your child's first dental visit? _____

Date of last dental visit: _____ Purpose of that visit? _____

What concerns you most about your child's mouth? _____

Mark "YES" or "NO" next to each item.

Does your child have a finger or thumb sucking habit? YES ○ NO ○

Does your child brush by himself/herself all the time? YES ○ NO ○

If no, who helps? _____

Has your child had any bad dental or medical experiences in the past? YES ○ NO ○

If yes, describe: _____

Rate the level of apprehension you think your child may have regarding dental treatment. (10 being the most apprehensive and 1 being the least)

○1 ○2 ○3 ○4 ○5 ○6 ○7 ○8 ○9 ○1 0

NOTES: