Battery Park KIDS PEDIATRIC DENTISTS

375 South End Avenue, Suite B
New York, NY 10280
Call or Text: (212) 786-0930
Fax: (212) 656-1430
E-Mail: contact@batteryparkpediatricdentists.com

Dental History

What is the reason for the patient's visit today?

_____

Previous Dentist's Name _____
Telephone _____

How often does the patient brush their teeth? _____
How often does the patient floss? _____

Has the patient ever used or are you currently using topical fluoride?	Yes	No

What other dental aids does the patient use (Interplak, toothpick, etc.)?

_____

Has the patient ever been told to take a pre-medication prior to dental treatment?	Yes	No
Is there anything else about having dental treatment that you would like us to know?	Yes	No

If yes, please describe:

_____

Are any of the patient's teeth sensitive to Hot or cold?	Yes	No
Are any of the patient's teeth sensitive to Sweets?	Yes	No
Are any of the patient's teeth sensitive to Biting or chewing?	Yes	No
Have you noticed any mouth odors or bad taste?	Yes	No
Does the patient frequently get cold sores, blisters or any other oral lesions?	Yes	No
Does the patient's gums bleed or hurt?	Yes	No
Have you noticed any loose teeth or change in the patient's bite?	Yes	No
Does food tend to become caught in between the patient's teeth?	Yes	No

If yes, where?

_____

Does the patient clench or grind your teeth while awake or asleep?	Yes	No
Bite their lips or cheeks regularly?	Yes	No
Mouth breathe while awake or asleep?	Yes	No
Have tired jaws, especially in the morning?	Yes	No
Snore or have any other sleeping disorders?	Yes	No
Smoke/chew tobacco or use other tobacco products?	Yes	No
Has the patient ever had Orthodontic treatment?	Yes	No

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A bite plate or mouth guard?	Yes	No
A serious injury to the mouth or head?	Yes	No
If yes, please describe, including cause		

_____

Has the patient experienced clicking or popping of the jaw?	Yes	No
Difficulty in opening or closing the mouth?	Yes	No
Difficulty in chewing on either side of the mouth?	Yes	No
Headaches, neck aches or shoulder aches?	Yes	No
Sore muscles (neck, shoulders)?	Yes	No
Does the patient feel nervous about having dental treatment?	Yes	No
If so, what is their biggest concern?		

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