Welcome to Dr. Pamela Weitzel's Dental Practice

Patient's First Name _____Last Name_____

Middle initial_____ Nickname_____ DOB _____/_____/_____

Parent's Name _____

Do you or your child have any concerns regarding his/her teeth at this time? YES / NO

If yes, please explain_____

Is this your child's first visit to a dentist? YES/NO If no, how long since last visit_____

Were any x-rays taken at that time? YES /NO

When does your child brush his/her teeth? _____

Does your child receive fluoride? YES /NO

If yes, how_____

Has your child ever received sealants? YES / NO Has your child ever received local anesthetic? YES / NO

Have you been told your child has cavities in the past? YES / NO

If so, were they treated? _____

Has your child had any teeth, baby or permanent, extracted? _____

Was an appliance placed? YES / NO

Has your child suffered any injuries to his/her teeth (such as a chip?) YES / NO

If so, what _____

How often does your child consume sweets, sticky foods or soda? _____

Has your child had any bad dental experiences? YES / NO

If yes, please explain_____

Have you or any one in your family had orthodontics? YES / NO

CHILD DENTAL HISTORY