Dr. Robert DiChristofano
Dr. Peter A. DiChristofano

7615 W. Montrose Ave.
Norridge, IL 60706
(708) 453-0777

Child Dental History

What is the purpose of this visit?

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Questions:	Yes	No
1. Is this your child's first dental visit to the dentist? ------------------------------	☐	☐
2. Were any X-rays taken at a previous dental visit? -----------------------------	☐	☐
3. Does your child brush his/her teeth? ---	☐	☐
4. Does your child floss his/her teeth? --	☐	☐
5. Does your child get help from an adult to brush or floss their teeth? ------	☐	☐
6. Does your child receive fluoride? --	☐	☐
7. Have any cavities been noted in the past? --	☐	☐
8. Were any teeth removed by extraction? --	☐	☐
9. Have there been any injuries to the teeth? ---------------------------------------	☐	☐
10. Has your child had any problem with dental treatment in the past? -----	☐	☐
11. Has you child ever received local anesthetic? ---------------------------------	☐	☐
12. Does your child require pre-medication? ---------------------------------------	☐	☐
13. Does your child do any of the following?		
~ Use baby bottle/ sippy cup---	☐	☐
~ Tongue thrusting/ Lisping ---	☐	☐
	☐	☐

~ Snoring ---

~ Mouth breathing -- ☐ ☐

~ Thumb/finger sucking-- ☐ ☐

Has your child ever had the following?

14. Discomfort, clicking or popping in jaw --- ☐ ☐

15. Red, swollen, or bleeding gums --- ☐ ☐

16. Sensitive tooth, teeth, or gums --- ☐ ☐

17. Blisters or sores in or around the mouth -------------------------------------- ☐ ☐

18. Lost or broken fillings --- ☐ ☐

19. Teeth grinding -- ☐ ☐

20. Ringing in the ears --- ☐ ☐

21. Broken or chipped teeth -- ☐ ☐

22. Stained teeth -- ☐ ☐

23. Loose teeth -- ☐ ☐

I certify that the above information is complete and accurate.

Parent's/ Guardian's signature _________________________________ **Date** __________

Dentist's signature ____ **Date** __________