

**michelle giumenta, dds
pediatric dentistry**

child's dental history:

What is the reason for this visit? _____

Is this the child's first visit to a dentist? yes _____ no _____

Has the child received dental treatment? yes _____ no _____

If yes, what was done? _____

Has the child had any major injuries to the mouth, teeth or head? yes _____ no _____

If yes, when and how? _____

Has the child ever had a toothache? yes _____ no _____

If yes, explain: _____

Was the child breast fed? yes _____ no _____

Did the child use a nursing bottle? yes _____ no _____

Did the child go to sleep with the bottle? yes _____ no _____

Did the child use a pacifier? yes _____ no _____

Did the child suck his/her thumb or fingers? yes _____ no _____

Does the child brush his/her teeth? yes _____ no _____

How often? _____ Do you help? yes _____ no _____

How would you describe the child's eating habits? _____

What does the child snack on and how often? _____

Has the child had an unpleasant dental or medical experience? yes _____ no _____

How do you think the child will react to this visit? _____

Does the child have any problems concentrating, learning, cooperating or understanding? _____

How does the child react without you in a new and possibly stressful situation? _____

I hereby certify that all the above information is true and correct. I understand that Dr. Giumenta does not take insurance and that payment is expected for service at the time it is rendered. I give consent for my child to be examined and receive dental treatment by Dr. Giumenta.

Signature: _____ Date: _____

Relationship to patient: _____