OAKVILLE DENTAL CARE

We're glad you're here.

To better serve you, please take just a couple of minutes to answer the following questions. Thanks!

Please check any of the following problems that apply to your child:

- ○ Sensitivity (hot, cold or sweet)
- ○ Neckaches, earaches, neck pain
- ○ Teeth or fillings breaking
- ○ Grinding or clenching teeth
- ○ Bleeding, swollen or irritated gums
- ○ Loose, tipped or shifting teeth
- ○ Bad breath
- ○ Jaw Pain
- ○ Food impaction

Does your child have, or have they ever had, orthodontics (braces)? ○ **Yes** ○ **No**

How often does your child brush?

How often does your child floss?

Is this your child's first visit to a dentist? ○ **Yes** ○ **No**
If not, when was the last visit date? _____

Has your child ever had dental radiographs (x-rays)?
○ **Yes** ○ **No**

Does your child have any fear or anxiety about going to the dentist? ○ **Yes** ○ **No**

Are you familiar with Nitrous Oxide Sedation (laughing gas)? ○ **Yes** ○ **No**

Please define your child's eating habits:

_____

_____

_____

Does your child have any oral habits such as thumbsucking, pacifier use, or nailbiting?
○ **Yes** ○ **No**

Has your child ever had any injuries to the mouth, head or teeth?
○ **Yes** ○ **No**

Has your child ever had any problems with the eruption or shedding of teeth?
○ **Yes** ○ **No**

Does your child participate in active recreational activities?
○ **Yes** ○ **No**

On a scale of 1 to 5, with 5 being the highest rating:
(please circle the number that best applies)

How important to you is your child's dental health?

1 2 3 4 5

How would you rate your child's current dental health?

1 2 3 4 5

Where would you like your child's dental health to rate?

1 2 3 4 5

What are the most important things to you about your child's smile and oral health?

What is the most important thing to you about your child's dental visit today?