

**Naples Pediatric Dentistry  
Dental History**

- Age until bottle-fed? \_\_\_\_\_  N/A
- Age until breast-fed? \_\_\_\_\_  N/A
- Is this your child's first visit to the dentist? .....  Yes  No
- Is your child experiencing dental pain right now? .....  Yes  No
- Has your child had dental pain/toothaches in the past? .....  Yes  No
- Does your child grind his/her teeth? .....  Yes  No
- Does your child bite or suck his/her cheek, lips or thumb? ....  Yes  No
- Do you think there is anything wrong with your child's teeth right now? .....  Yes  No
- Are you nervous about this appointment? .....  Yes  No
- Do your child's gums bleed when they are brushed or flossed?  Yes  No
- Does your child use fluoride products? .....  Yes  No  
Rinse, drops or tablets? (please circle whichever is used)
- Is your child's water fluoridated? .....  Yes  No
- Does your child eat well-balanced meals? .....  Yes  No
- How often does your child brush? \_\_\_\_\_
- How often does your child floss? \_\_\_\_\_
- Do you assist your child with brushing and flossing? .....  Yes  No

**AUTHORIZATION AND RELEASE**

I authorize Dr. Sandor to examine the above-named patient and perform the dental procedures explained to me, including the taking of any necessary dental radiographs to evaluate the oral health of my child.

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental office of any changes in my child's medical status.

I authorize Dr. Sandor to release the records of any treatment or examination rendered to my child during the period of such dental care to other health practitioners as required for the purposes of caring for my child's health. I understand that this office does not accept assignment of benefits. I understand that I am directly responsible for the payment of all services rendered on behalf of my child. My insurance company will reimburse me directly according to the terms of my policy. I understand that if it is necessary for Naples Pediatric Dentistry to seek legal consultation for collection actions, I am financially responsible for the unpaid debt and any necessary attorney and court fees required to collect that debt.

\_\_\_\_\_  
Signature of Parent or Guardian

\_\_\_\_\_  
Date