

**We want to make sure we address all of your concerns and
your child's needs.....**

Patient Name: _____

At present are you aware of any problems with your child's oral health?

No Yes Please Explain: _____

Does your child have any pain? **Unsure () Yes () No ()**

Do your child's gums bleed when brushing? **Unsure () Yes () No ()**

Are your child's teeth sensitive to sweets, temperature (hot/cold) & or biting pressure?
Unsure () Yes () No ()

Does dental treatment make your child nervous?

NO Slightly Moderately Very **Unsure ()**

I think my child dental health is.....

Excellent Good Fair Poor **Unsure ()**

Any other concerns/needs I would like Dr. Worden to be aware of are:

**If this is not your child's first visit to the dentist when the last time your child was
seen by a dentist and what was done on that appointment?**

_____.

