Dr. Gremillion
New Patient Supplemental Questions From

Dino Smiles

DINO SMILES

Patient Name	☐ Male ☐ Female	Date of Birth

SUPPLEMENTAL HISTORY QUESTIONS FOR AN INFANT/TODDLER (please complete for 0- 4 years):

Was your child born prematurely?..... ☐YES ☐NO If YES, what week? _____ _____

What was your child's birth weight?_____

How long was your child breastfed? .... ☐ N/A ☐ less than 6 months ☐ 6-11 months ☐ 12-17 months ☐ 18-23 months ☐ 2 years or more

How long was your child bottlefed? ..... ☐ N/A ☐ less than 6 months ☐ 6-11 months ☐ 12-17 months ☐ 18-23 months ☐ 2 years or more

Do/did you feed your child infant formula?..... ☐YES ☐NO If YES, what type? ☐ Ready to use ☐ Powdered ☐ Liquid concentrate

Does/did your child sleep with a bottle?..... ☐ YES ☐ NO If YES, content of bottle? _____ _____

Does/did your child use a no spill training cup (sippy cup)?..... ☐ YES ☐ NO

Child's age (in months) when first tooth appeared in mouth _____

Has your child experienced any teething problems?..... ☐ YES ☐ NO

When did you begin brushing his/her teeth?..... ☐ N/A ☐ less than 6 months ☐ 6-11 months ☐ 12-17 months ☐ 18-23 months ☐ 2 years or more

When did you begin using toothpaste?..... ☐ N/A ☐ less than 6 months ☐ 6-11 months ☐ 12-17 months ☐ 18-23 months ☐ 2 years or more

Who is your child's primary care taker during the day? _____ during the evening? _____

_____ _____ _____
Signature of parent/guardian Relationship to child Date

SUPPLEMENTAL HISTORY QUESTIONS FOR AN ADOLESCENT PATIENT (to be completed by the patient 12 years and older):

Do you have any concerns about your mouth, teeth or oral health?..... ☐ YES ☐ NO If YES, describe:_____ _____

Have you recently experienced any dental/oral pain?..... ☐ YES ☐ NO If YES, describe:_____ _____

Do you have any concerns with the appearance of your teeth or smile? ☐ YES ☐ NO If YES, describe:_____ _____

Do you bleach your teeth?..... ☐ YES ☐ NO If YES, how often: _____ _____

Have there been any recent changes in your dietary habits?..... ☐ YES ☐ NO If YES, describe:_____ _____

Are you taking any dietary or herbal supplements?..... ☐ YES ☐ NO If YES, describe:_____ _____

Do you participate in contact sports or high speed sports (skiing, motorcycles)? ..... ☐ YES ☐ NO If YES, describe:_____ _____

_____

Signature of Parent/Guardian _____ Relationship to Patient _____

Print Name _____ Date _____