Order of baby teeth eruption

What primary tooth eruption means

Primary tooth eruption is the movement of a developing tooth from the jawbone through the gingiva into the mouth. The crown of each tooth forms before it is visible, while roots continue to develop after eruption. By the time the full primary dentition is present, most children have 20 baby teeth: 10 in the maxilla, or upper jaw, and 10 in the mandible, or lower jaw.

These teeth are temporary, but they are not optional placeholders. They support chewing, speech articulation, jaw development, facial growth, and spacing for permanent teeth. Premature loss from decay or trauma can affect alignment, nutrition, and comfort. This is why the order of eruption matters less as a competition and more as a useful developmental map.

In a Normal baby development timeline, tooth eruption is only one sign among many. Clinicians interpret it alongside growth curves, feeding ability, neurologic development, medical history, and family patterns. A single late tooth rarely tells the whole story.

The usual order of baby teeth eruption

The most common sequence begins at the front of the mouth and gradually moves backward, although individual children may vary. Research and clinical eruption charts generally describe the same pattern: mandibular central incisors first, then maxillary central incisors, lateral incisors, first molars, canines, and finally second molars.

Lower central incisors: often the first teeth to appear, commonly around 6 to 10 months.
Upper central incisors: frequently erupt next, often around 8 to 12 months.
Upper lateral incisors: commonly appear around 9 to 13 months.
Lower lateral incisors: often follow around 10 to 16 months.
First molars: usually erupt before canines, often between about 13 and 19 months in the upper jaw and 14 to 18 months in the lower jaw.
Canines: also called cuspids, commonly erupt around 16 to 23 months.
Second molars: typically complete the primary dentition, often between about 23 and 33 months.

This sequence can surprise caregivers because the first molars often come in before the canines. The gap between the lateral incisors and first molars may look unusual, but it is a normal part of primary dentition development.

A practical eruption timeline by age

Age ranges are best understood as approximations, not deadlines. Many babies begin eruption at about 6 months, and many have a full set of primary teeth by around 3 years. Some healthy infants erupt teeth earlier; others erupt later because of genetic timing, prematurity, nutritional factors, endocrine conditions, systemic illness, or simply normal biologic variation.

From birth to 6 months, teeth are usually not visible, although dental development is already underway inside the jaws. Rarely, an infant is born with a natal tooth or develops a neonatal tooth in the first month. These situations should be assessed by a clinician because mobility, feeding interference, and aspiration risk may need evaluation.

Between 6 and 12 months, the incisors often emerge. These front teeth help babies bite soft foods, but they are not required before solids begin. Developmental readiness for solids depends more on head control, sitting

support, oral-motor skills, interest in food, and safe swallowing than on having teeth.

Between 12 and 24 months, the mouth changes quickly. First molars may erupt and create more chewing surface, then canines fill the space between incisors and molars. Between 24 and 36 months, second molars usually arrive, completing the primary dental arch.

If your child was born preterm, clinicians may consider corrected age for some developmental expectations. Dental eruption can still vary, and the best interpretation comes from combining birth history, growth, nutrition, and oral examination rather than focusing on a single date.

Why some babies get teeth earlier or later

Development differences between babies are common, and tooth eruption is no exception. Family history is a major influence: if parents or siblings got teeth late, a baby may follow a similar pattern. Sex-based and population-level differences have been reported in eruption studies, but they are not precise enough to predict an individual child’s timing.

Several clinical factors can influence eruption timing. Prematurity and low birth weight may be associated with later eruption in some children. Nutritional deficiencies, chronic systemic disease, endocrine disorders such as hypothyroidism, and certain genetic syndromes can also affect tooth formation or eruption. Local factors, such as a missing tooth germ, cyst, scar tissue, or obstruction, may affect one tooth or one side more than the whole mouth.

That said, most variation is benign. A child who is feeding well, growing along an expected curve, meeting developmental milestones, and has a normal oral examination may simply be on the later end of the eruption spectrum. An infant well-child visit schedule gives repeated opportunities for pediatric clinicians to monitor the mouth, growth, and broader development over time.

Teething symptoms: what is typical and what is not

Tooth eruption can cause local gingival inflammation as the tooth approaches and penetrates the gum. Caregivers often notice drooling, a desire to chew,

mild irritability, disrupted sleep, facial rubbing, or decreased appetite for a short period. The gum overlying an erupting tooth may look swollen, pale, or slightly reddened.

However, teething is often blamed for symptoms that may have another cause. High fever, persistent diarrhea, repeated vomiting, dehydration, marked lethargy, breathing difficulty, a widespread rash, or severe inconsolable crying should be discussed with a healthcare professional. These symptoms may coincide with teething because infancy is also a time of frequent viral infections, but coincidence is not proof of causation.

Comfort measures should be conservative. A clean chilled teething ring, gentle gum massage with a clean finger, and extra soothing are commonly used. Avoid teething necklaces because of strangulation and choking risk. Avoid products with unsafe numbing agents unless specifically recommended by a clinician, because some topical anesthetics can cause serious adverse effects in infants and young children.

Caring for teeth as they erupt

Oral care begins before teeth appear. Wiping the gums with a clean, damp cloth can help establish a routine and remove milk residue. Once the first tooth erupts, gentle brushing becomes important. Many dental organizations recommend using a smear-sized amount of fluoride toothpaste for children under 3, but families should follow local dental guidance and discuss individualized fluoride needs with a pediatric dentist or pediatrician.

Early childhood caries can begin soon after teeth erupt. Risk is higher with frequent exposure to fermentable carbohydrates, prolonged bottle use with milk or juice, sleeping with a bottle, enamel defects, inadequate fluoride exposure, and transmission of cariogenic bacteria. Breastfeeding itself is not automatically harmful to teeth, but frequent nighttime feeding after teeth erupt should be discussed in the context of the child’s overall caries risk and family feeding goals.

A first dental visit is often recommended by the first birthday or within about 6 months after the first tooth appears, depending on local guidance and risk factors. This visit is not only for finding cavities. It can cover eruption

patterns, brushing technique, fluoride, feeding habits, trauma prevention, pacifier or thumb habits, and what to do if a tooth is chipped or displaced.

When baby teeth fall out later

The primary teeth usually shed in a pattern that resembles their eruption sequence. Lower central incisors are often among the first to loosen, followed by upper central incisors, lateral incisors, first molars, canines, and second molars over the school-age years. Permanent teeth erupt underneath or behind the baby teeth and gradually resorb the primary roots.

Just as eruption varies, shedding varies. A permanent tooth may appear behind a baby tooth, sometimes called a double row or shark tooth appearance. This can be common, especially in the lower incisors, but a dentist can assess whether the baby tooth is likely to loosen on its own or whether monitoring is needed.

Keeping baby teeth healthy until their natural exfoliation matters. A decayed or abscessed primary tooth can cause pain, affect eating and sleep, and potentially influence the developing permanent tooth. Prompt dental evaluation is appropriate for swelling, drainage, trauma, discoloration after injury, or persistent tooth pain.

When to seek professional guidance

Caregivers do not need to measure every tooth against a chart, but some patterns deserve assessment. Consider contacting a pediatric dentist or pediatrician if no teeth have erupted by around 12 to 18 months, if eruption is markedly asymmetric, if a tooth looks malformed or severely discolored, if gums are persistently swollen in one area, or if a baby seems unable to feed comfortably because of an oral finding.

Urgent guidance is appropriate for facial swelling, fever with oral swelling, trauma that loosens or displaces a tooth, bleeding that does not stop with gentle pressure, signs of dehydration, or a baby who appears very unwell. Dental infections in young children can progress quickly and should not be managed at home without professional evaluation.

It is also reasonable to ask about tooth eruption during routine pediatric

care. Parents are not being overcautious by raising questions; early reassurance or early referral can both be valuable. The goal is not to force every child into an exact timeline, but to identify the small number of children whose eruption pattern reflects a dental, nutritional, endocrine, or systemic issue.