DENTAL HEALTH CARE CENTER

appointments@dentalhealthcarecenter.com
1717 EAST 66TH STREET • Richfield, MN 55423 (612)861-7109

PEDIATRIC DENTAL HISTORY

Patient Name: _____ _____ ___ _____
Last First MI Preferred Name

Has your child ever been to the dentist? * ◯ Yes ◯ No

Date of last cleaning and X-rays (if taken)

Name of previous Dentist:

Have your child's teeth ever been injured? * ◯ Yes ◯ No

If yes, please describe:

Does your child suck a finger, thumb or pacifier? * ◯ Yes ◯ No

If yes, until what age?

Does your child go to bed with a bottle or sippy cup? * ◯ Yes ◯ No

Name and ages of other children in your family:

Please select if your child is having problems with any of the following:

- ☐ Cavities
- ☐ Toothache
- ☐ Sensitive Teeth
- ☐ Mouth Breathing
- ☐ Trauma
- ☐ Gum Infections
- ☐ Orthodontics
- ☐ Jaw sounds
- ☐ Grinding of teeth
- ☐ Color of teeth
- ☐ Snoring
- ☐ Lisp/speech problems
- ☐ Trouble breathing/struggling to breath

Other

Fluoride History

Is your home water supply fluoridated? * ◯ Yes ◯ No

If yes, name of company:

_____

_____

Does your child use a fluoride toothpaste? * ◯ Yes ◯ No

Do you give your child any other forms of fluoride? * ◯ Yes ◯ No

If yes, what?

_____

_____

I affirm that the information above is correct to the best of my knowledge. I understand it is my responsibility to inform Dental Health Care Center of any changes in my child's medical status.

Signature _____ **Date** _____

Response Date: ____/____/_____