

DENTAL HEALTH CARE CENTER

1717 EAST 66TH STREET

Richfield, MN 55423

(612)861-7109

appointments@dentalhealthcarecenter.com



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

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Name and ages of other children in your family:

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

- | | |
|---|---|
| <input type="checkbox"/> Cavities | <input type="checkbox"/> Toothache |
| <input type="checkbox"/> Sensitive Teeth | <input type="checkbox"/> Mouth Breathing |
| <input type="checkbox"/> Trauma | <input type="checkbox"/> Gum Infections |
| <input type="checkbox"/> Orthodontics | <input type="checkbox"/> Jaw sounds |
| <input type="checkbox"/> Grinding of teeth | <input type="checkbox"/> Color of teeth |
| <input type="checkbox"/> Snoring | <input type="checkbox"/> Lisp/speech problems |
| <input type="checkbox"/> 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

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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: