

Make a Child's Smile – DENTAL HISTORY FORM

Name of Child _____ Date of Birth _____

Is your child allergic to any medication? Yes___ No ____ If yes, what is the name of the medicine? _____

- 1) How is the mother's or guardian's dental health? Choose one.
 - has untreated tooth decay
 - has no obvious tooth decay / has healthy teeth
 - unknown
- 2) How often does your child see a dentist? Choose one.
 - for emergencies only
 - regularly, to receive preventive care and other needed care
 - has not seen a dentist
- 3) How does your child usually go to bed? Choose one.
 - with a cup, sippy cup or bottle of juice, milk, formula, or something sweet
 - with a pacifier dipped in something sweet
 - after falling asleep breastfeeding
 - none of the above
 - does not apply
- 4) What does your child usually drink? Choose one.
 - tap water
 - bottled water
 - sweetened drinks (such as juice, sweet tea, sodas, or chocolate milk)
 - white milk
- 5) Does your child have special healthcare needs? For example, these include diabetes, HIV infection, asthma, or birth defects.
 - Yes
 - No
- 6) Is the child's mother or guardian receiving support through, or eligible for, one of the following? Choose one.
 - Medicaid only
 - Medicaid and WIC
 - WIC only
 - none of the above
 - unknown
- 7) Does your child have any brothers or sisters with untreated cavities?
 - yes
 - no
 - not applicable
- 8) How often does your child eat snacks between meals? Choose one.
 - frequently (all day long at no specified times)
 - occasionally (only 1-3 snacks at specific times a day)
 - rarely
 - unknown
- 9) When your child snacks at home on a typical day, which snacks are the most common? Choose one.
 - candy, cookies, snack cakes, chips, pretzels or other snack foods
 - raw fruits or vegetables such as apples, grapes, carrots, celery, etc.
 - nothing/the child does not snack between meals
 - unknown

Return this form with the parental consent form to the Child Care Center.