

Port Pediatric Dentistry, PC
Suzanne K Port, DDS MS
291 West Lakewood Blvd Holland, MI 49424
Phone: 616-392-1100

Dental and Fluoride History

Child's Name: _____

DENTAL HISTORY

What is the reason for you today's dental visit? _____

Yes No Has your child ever been to the dentist?

Name of previous dentist _____ Date of visit _____

Yes No Were x-rays taken?

Yes No Did your child have difficulty cooperating?

Explain _____

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

Yes No Was your child bottle fed?

Yes No Was your child breast fed?

What age were they weaned? _____

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

What is in the sippy cup? _____

Yes No Do you assist your child's tooth brushing?

When does your child brush?

Upon rising Right after meals After eating any food Before bed

Yes No Has your child's teeth ever been injured? Which teeth? _____

Yes No Do you expect your child to be cooperative?

Does your child have any of the following issues?

Cavities Toothache Sensitive Teeth Mouth Breathing Trauma
 Gum Infections Jaw Sounds Grinding of Teeth

Yes No Does your child see an orthodontist? If so, name of orthodontist: _____

FLUORIDE HISTORY

Yes No Does your house have well water?

Has your well ever been tested for fluoride levels? Yes No

Yes No Does your child use fluoridated toothpaste?

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

What? _____

Signature of Parent/Guardian

Date