I-CARE, Inc.
Dental Health History

Child's Name _____ DOB _____

1. Does the family have a regular dentist? ☐ Yes ☐ No
   Date of last visit: _____

Dentist name or practice _____

2. Has child been examined by a dentist? Yes ☐ No ☐
3. Is child being treated by a dentist? Yes ☐ No ☐

Nature of treatment _____

4. Does child brush his/her teeth regularly? Yes ☐ No ☐
5. Does parent supervise child's tooth brushing? Yes ☐ No ☐
6. Has child ever complained about: Teeth____ Gum ____ Mouth ____ Yes ☐ No ☐
   If yes, explain _____
7. Has child ever had tooth pulled? Yes ☐ No ☐
8. Has child ever had accident involving the mouth? Yes ☐ No ☐
   If yes, explain _____
9. Has child lived in area with fluoridated water? Yes ☐ No ☐
10. Has child ever taken a dietary fluoride supplement? Yes ☐ No ☐
11. Does child have any of the following habits?

    Thumb sucking ☐ Lip biting ☐ Lip sucking ☐ Pacifier ☐

    Nail biting ☐ Bottle to sleep ☐ Bottle during day ☐
12. Was your child breast fed? Yes ☐ No ☐
13. Does your child still breast feed? Yes ☐ No ☐
14. Does child receive WIC? Yes ☐ No ☐

Parent Signature: _____ Date: _____

Updated: 5/20