Rising Sun Children's Center

5224 Rising Sun Ave.

Philadelphia PA 19120

Phone: 215 457 7730 / Fax: 215 689 4547

DENTAL HEALTH

Child's Name____ Birth Date: _______________

Dear Parent/Guardian,

- Please complete Part I to the best of your knowledge
- Part II is to be completed by your child's dentist

Part I ~ Completed by Parent/ Guardian

1. Has your child been to the dentist? _____ No ____Yes ~ If Yes, please complete the following:

Dentist Name____________________

Address____Zip____________

Phone Number__________________ Date of child's last dental visit_______________

2. Does your child have (or had) cavities or caries? _______No ________Yes ~ If Yes, How Many? ____

3. Does your child have any problems with his/her teeth, gums, or mouth? ____ No ____ Yes

If Yes, please describe____

4. How many times a day does your child brush his/ her teeth? _____________________

Part II ~ Completed by child's dentist

1. Date of child's most recent:

Dental Examination _____ Teeth Cleaning ___________ Fluoride Treatment______________

2. Has child ever needed dental treatment? _________No __________ Yes

If yes, type of dental treatment ____

Has dental treatment been completed? _______ No _______ Yes ~ If Yes, date of completion____

3. Date of child's next dental visit _____________

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Dental Office Stamp

My signature citifies the accuracy of this information

Dentist's Signature ___________________________

Date ___________________