THE SCHOOL DISTRICT OF PHILADELPHIA

OFFICE OF EARLY CHILDHOOD EDUCATION

EDUCATION CENTER

440 N. BROAD STREET, Suite 170

PHILADELPHIA, PENNSYLVANIA 19130-1099

TELEPHONE 215-400-4270 FAX 215-400-4275

DENTAL HEALTH

Child's Name _____ Birth Date _____ Center _____

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 _____

My signature certifies the accuracy of this information.

Dentist's Signature _____

Date _____

Dental Office Stamp

IT'S TIME TO GO TO THE DENTIST!

Child's Name: _____ Date: _____

PHILADELPHIA HEALTH CENTERS FOR DENTAL CARE

HC #2	1720 S. Broad Street, 19145	215-685-1822
HC #3	555 S. 43rd Street, 19104	215-685-7506
HC #4	4400 Haverford Avenue, 19104	215-685-7605
HC #5	1920 N. 20th Street, 19121	215-685-2938
HC #6	321 W. Girard Avenue, 19123	215-685-3815
HC #9	131 E. Chelten Avenue, 19144	215-685-5738
HC #10	2230 Cottman Avenue, 19149	215-685-0608

HOSPITAL-BASED DENTAL CLINICS

ST. CHRISTOPHER'S
Front & Erie Avenue
Dental Office
215-427-5065

EPISCOPAL
Front & Lehigh Avenue
Dental Office
215-707-1030

TEMPLE
3233 S. Broad Street
School of Dentistry
215-707-2863

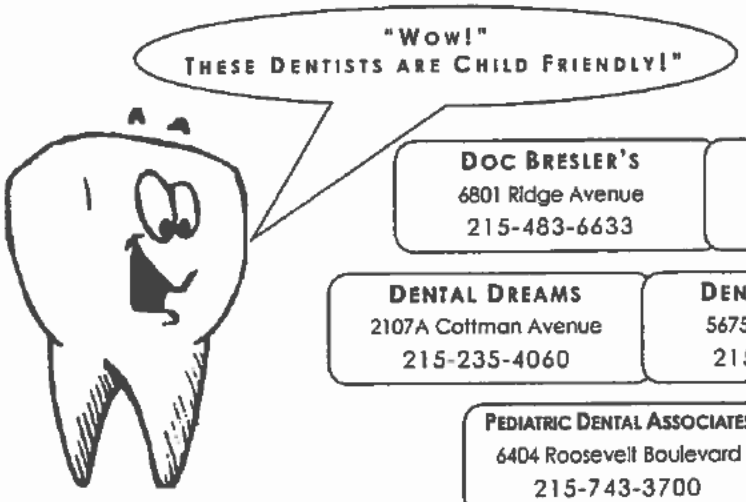
EINSTEIN
York & Tabor Road
Dental Office
215-456-7130

UNIVERSITY OF PENNSYLVANIA
40th & Spruce Street
School of Dentistry
215-898-8979

FEDERALLY FUNDED CLINICS

FAIRMOUNT HEALTH CENTER
1412 Fairmount Avenue
Dental Office
215-684-5349

MARIA DE LOS SANTOS HEALTH CENTER
401 W. Allegheny Avenue
215-291-2500



KIDS SMILES
2821 Island Avenue, Suite 210
215-492-9291

KIDS SMILES II
5848 Market Street
215-747-6901

DOC BRESLER'S
6801 Ridge Avenue
215-483-6633

DOC BRESLER'S
1430 Snyder Avenue
215-467-6000

DOUGLAS R. REICH, D.M.D.
7122 Rising Sun Avenue
215-725-8300

DENTAL DREAMS
2107A Cottman Avenue
215-235-4060

DENTAL DREAMS
5675 N. Front Street
215-224-0440

DENTAL DREAMS
2459 Aramingo Avenue
215-427-2800

PEDIATRIC DENTAL ASSOCIATES
6404 Roosevelt Boulevard
215-743-3700

PEDIATRIC DENTAL ASSOCIATES
100 E. Lehigh Avenue
215-707-1030

1-800-DENTIST : TOLL-FREE INFORMATION (NATIONWIDE)

215-925-6050 : PHILADELPHIA COUNTY DENTAL SOCIETY
(for private dentists in your area)

Job 08/10rev

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440 N. BROAD STREET, SUITE 170
PHILADELPHIA, PENNSYLVANIA 19130

NUTRITION HISTORY

Parent/Guardian: Please complete both sides of this form to the best of your knowledge.

Child's Name _____ Today's Date _____

1. What foods does your child like? _____
2. What foods does your child dislike? _____
3. Place a check mark in the No or Yes column next to each question:

	No	Yes
Does your child take vitamins?		
Do the vitamins contain iron?		
Do the vitamins contain fluoride?		
Are the vitamins prescribed by a doctor?		
Is your child on a special diet?		
Is the diet recommended by a doctor?		
Has there been a noticeable change in your child's appetite in the last month?		
Does your child drink from a bottle?		
Does your child eat or chew things that aren't food? (ex: dirt, clay, paint chips)		
Does your child have trouble chewing or swallowing?		
Does your child often have diarrhea?		
Does your child often have constipation?		
Do you have any concerns about what your child eats?		
Are you receiving WIC?		
Are you receiving Food Stamps?		

4. Place a check mark under the column that indicates the approximate number of times a week your child eats the following foods:

	0	1	2	3	4	5	6	7	7+
Milk ~ whole, skim, low fat, lactose free									
Cheese, yogurt									
Eggs									
Peanut butter									
Beans, peas, soy, tofu, lentils									
Nuts, seeds									
Beef, chicken, turkey									
Fish, shellfish									
Rice, noodles, bread, tortillas, crackers, cereal									
Green vegetables, spinach, collard greens									
Winter squash, pumpkin, sweet potatoes, carrots									
Oranges, grapefruit, tomatoes, broccoli, fruit juice									
Other fruits and vegetables									
Oil, butter, margarine, jams, jellies, olive oil									
Cakes, cookies, sodas, fruit drinks, candy									

Please complete other side

5. Where do you usually take your child for health care services (Medical Home)?

Name _____

Address _____ Zip _____ Phone number _____

6. Where do you usually take your child for dental care services (Dental Home)?

Name _____

Address _____ Zip _____ Phone number _____