Vantaan ja Keravan hyvinvointialue
Vanda och Kervo välfärdsområde

Preliminary information for dental care for school-age children

PRINT CLEAR FORM

The information is confidential

Date of arrival:

PATIENT DETAILS

Child´s name

Personal identity code

Address

Home telephone

School

Class

Child´s telephone number

Earlier dental care, year

Does the child have a general medical condition (i.e. diabetes, heart failure, asthma, kidney disease, rheumatism, hepatitis or another disease), which Does he/she have any other condition to be considered (i.e. development disability or another disability), what

Does the child have continuous medication

☐ no ☐ yes, what

Is the child allergic (hypersensitive) for something (i.e. penicillin)

☐ no ☐ yes, for what

Is the child prone to bleeding

Other things to be considered in dental care

HABITS AND FACTORS AFFECTING ORAL HEALTH

Brushing the teeth

☐ 2 times a day or more often ☐ once a day ☐ more seldom than once a day

Does the child use

fluoride toothpaste daily	☐ no	☐ yes
other fluoride product	☐ no	☐ yes
xylitol chewing gum or pastils	☐ no	☐ yes

The child eats daily

☐ breakfast ☐ lunch ☐ dinner ☐ snacks ____ times a day

Mealtime drink

Thirst quencher

Child´s use of sweets	daily use	2-4 times a week	once a week	less frequently or never
juices	☐	☐	☐	☐
juices with sugar, cocoa, tea	☐	☐	☐	☐
mineral waters, soft drinks	☐	☐	☐	☐
energy drinks	☐	☐	☐	☐
sweet pastries	☐	☐	☐	☐
candy	☐	☐	☐	☐
other sweet things what	☐	☐	☐	☐

Smoking

☐ no significant exposure to tobacco ☐ significant passive smoking

☐ smoking daily ____ cigarettes per day ☐ smoking occasionally

DATE AND SIGNATURES

Date

Signature of the child

Signature of the guardian

Signature of the guardian

Name clarification

Name clarification

Telephone during the day

Telephone during the day

PRINT CLEAR FORM