Child

Name_____ **Date**_____

Thank you for choosing our office for your child's dental care. It is our goal to work with you and your child in maintaining their best possible oral health.
At the first appointment you are welcome to accompany your child in the treatment room. During this time it is most beneficial if you allow us to communicate directly with your child in order to have their full attention and cooperation. You will be asked to fill out this questionnaire about habits including snacks, drinks and frequency of brushing and flossing. This questionnaire enables us to more accurately assess your child's dental health and anything that may contribute to current or future problems.

1. What concerns do you have about your child's dental health?_____
   _____
2. Is there fluoride in the water at home, child care or school? Yes / No
3. Does your child take a fluoride supplement? Yes / No
4. Does your child consume foods high in sugar? Yes / No
5. Does your child snack between meals? Yes / No
   Examples: _____
6. What types of drinks does your child have throughout the day?
   Examples: _____
7. Does your child chew gum or suck on hard candies? Yes / No
   How Often: _____
8. How often does your child brush their teeth? _____per_____
   Floss? _____per_____
9. Do you help with brushing and flossing? Yes / No
10. Does you child currently have braces? Yes / No
11. Has your child had any fillings in the last 3 years? Yes / No
12. Has anyone in the immediate family had fillings in the last 3 years? Yes / No
13. Does your child breathe through their *mouth* or *nose*? (circle one)
14. Have you noticed your child snoring most nights? Yes / No