



CHILD DENTAL HEALTH QUESTIONNAIRE

Purpose for initial visit? _____

How long ago was your child's last dental visit? _____

Have they had any unpleasant dental experiences in the past? _____

Is there anything we can do during the visit to make it a more enjoyable experience for your child? _____

YES NO Does your child brush more than once a day?

YES NO Does anyone else assist him / her with brushing their teeth?

YES NO Do they use dental floss?

YES NO Have you noticed his / her gums bleeding when brushing or flossing?

YES NO Are their teeth sensitive to cold, hot, or sweets?

YES NO Does he / she frequently consume food and beverages between meals?

YES NO Does he / she drink soda, energy drinks, or juice?

YES NO Does your home have well water?

YES NO If so, have you had the water tested?

Child's Name _____

Parent's Signature _____