Children 6 years & Older

Patient Name: ________________________

Preferred Name: ________________________

Age:______________

It's my child's first visit to the dentist.	YES		NO
-If NO. Complete #1-#2			
#1- How long ago was your child's last dental visit.	1 year or longer	6months to 1 year	6 months or less
#2- Were dental x-rays taken at your child's last dental visit	NO	I'm Not Sure	YES
My child receives fluoride. (drinking water, toothpaste, or supplements)	NO	I'm Not Sure	YES
My child is under 8 years old and has their teeth brushed daily by an adult.	NO	My child is over age 8	YES
My child has sugar containing snacks or drinks per day. (fruit snacks, candy, juice, soda or Gatorade)	More than 3x a day.	1-2 times a day.	Less than 1 time a day or never.
My child has special health care needs.	YES		NO

Additional comments or concerns:

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