Children 0-5 years old

Patient Name: _____

Preferred Name: _____

Age: _____

This is my child's first visit to the dentist.	YES		NO
My child receives fluoridated water/ fluoride supplements/ formula with fluoride.	NO		YES
My child has their teeth brushed daily by an adult.	NO		YES
My child has sugar containing snacks or drinks per day. (juice, chewy fruit snacks, candy)	More than 3x a day.	1-2 times a day.	Less than 1 time a day or never.
My child takes a bottle.	Throughout the Day or To Bed at Night.	With Meals Only	Never
-If a bottle is used what is in it. (check all that apply)	Juice	Milk or Formula	Water
My child has special health care needs.	YES		NO
I have an untreated cavity in my own mouth.	YES	I'm Not Sure	NO

Additional comments or concerns:

_____

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