Children 0-5 Years Old

Patient Name: ___________________________

Preferred Name: ___________________________

Age: ___________________

Question	Answer
Is this your child's first visit to the dentist? If no, when was his or her first visit?	
Whom may we thank for referring your child?	
Does your child receive fluoride in drinking water, toothpaste or supplements?	
Are your child's teeth brushed daily by an adult?	
How often does your child have sugar containing snacks or drinks per day? (fruit snacks, candy, juice, soda or Gatorade)	
Does your child have any special health care needs?	
Does your child take a bottle? If yes, what is used in it? (Juice, Milk, Formula, Water)	
Do you have an untreated cavity in your own mouth?	
Additional comments or concerns:	