CHILD ORAL HEALTH SURVEY

Child's Name____ Age_____ Date___________

This is a questionnaire that will help our health care professionals properly assess your child's current health status. Please take a moment to provide us with information that will enable us to help your child achieve optimum oral health.

Approximately when was your child's last dental cleaning? ________________________

Who brushes your child's teeth?____

Does your child spit or swallow the toothpaste? (please circle) Spit Swallow

Does your child floss? ___Yes ___No If yes, how often?_______________ Independently? ___Yes ___No

Does your child use mouthwash? ___Yes ___No If so, what brand?_______________________________________

What brand of toothpaste does your child use? ____

What type of toothbrush does your child use? ___Manual ___Electric ___Sonic

If you answered "manual", are the bristles? ___Hard __Medium ___Soft ___I don't know

Does your child use any other dental aids? (Circle those that apply)

	Sensitivity Toothpaste		Xylitol Chewing Gum		Floss Threaders		Superfloss
	Tongue Scrapers		Fluoride Rinse (ex. Act)		Prescription Toothpaste		Fluoride Tablets
	Floss Handles		Disposable Flossers		Disclosing Tablets		Disclosing Rinses

What is the major water source for your child? (please select one)

___Public Water Supply ___Private Well ___Bottled Water ___Filtered at refrigerator or sink

Does your child use a "sippy" cup? __Yes __No Does he/she take a "sippy" cup or any drink to bed? __Yes __No

Has your child ever worn braces? __Yes __No If so, does he/she currently wear retainers? __Yes __No

Are you interested in orthodontics (braces)? __Yes __No

Does your child play any contact sports? ___Yes __No If so, what?______________________________________

Is there any history of trauma to your child's head/neck/mouth? ___Yes ___No

Does your child clench or grind his/her teeth? ___Yes ___No

Does your child have any finger or thumb habits? ___Yes ___No If so, what? ___________________________________

Do you have any concerns about the potential use of nitrous oxide (laughing gas) with your child? ___Yes ___No

Can you give us any information that may help us to establish a nice rapport with your child (nickname, hobbies, interests)? ____

Do you have a problem or issue that you would like addressed today? If so, what is it? ___________________________

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Please feel free to ask any question that may allow you to become comfortable with our recommendations for your child's care.

We appreciate you choosing our dental office for your family's dental care.