Amy M. Roberts, DDS **Child's Name**_________________________
Date _______________ **Child's Age** _____ **Child DOB** __________

To help us assess your child's dental needs, please answer these questions. Thank you.

HEALTH HISTORY	Yes	No
Did birth mother have any problems during pregnancy?	☐	☐
Has your child needed frequent use of liquid medication?	☐	☐
Has the parents, caretaker seen a dentist in the last year?	☐	☐

Notes: ____

DIET AND NUTRITION	Yes	No
Is/was your child breastfed?	☐	☐
Does your child sleep with a bottle?	☐	☐
Does your child drink from a sippy cup?	☐	☐
Is your child on a special diet?	☐	☐

Notes: ____

FLUORIDE ADEQUACY	Yes	No
Do you have well water?	☐	☐
If yes, has the water been tested for fluoride content?	☐	☐
Does the water source where you child resides most of the day have a filtration system?	☐	☐

Notes: ____

ORAL HABITS	Yes	No
Does your child have any oral habits?(Sucks thumb, finger, pacifier, etc)	☐	☐

Notes: ____

ORAL DEVELOPMENT	Yes	No
Does your child have teeth?	☐	☐
Child's age (in months) when first tooth erupted? __________________		
Has your child experienced teething problems?	☐	☐

Notes: ____

ORAL HYGIENE	Yes	No
Do you clean your child's teeth/gums?	☐	☐
Does your caretaker clean your child's teeth/gums?	☐	☐
Do you use a toothbrush to clean your child's teeth?	☐	☐
Do you use toothpaste to clean your child's teeth?	☐	☐
Do you, your significant other/caretaker have untreated dental needs?	☐	☐

If yes, who? ____
Notes: ____

Circle: Mother Father Guardian Signature: ________________________________