Let's Talk Teeth!

Parent's Name: ______________________ Child's Name: _________________ Child's Age: ________

Answer the following questions about your child: *(note: some questions may not apply based on the age and developmental stage of your child.)*

	Yes	No	NA
1. If your child has teeth, do you brush them? **If YES:** Times per day _________ Times of day _________ Days per week _________	☐	☐	☐
2. Does your child drink anything besides water between meals and snacks? **If YES:** What does she drink? _________________________How often? _________	☐	☐	☐
3. Does your child go to bed with a bottle filled with anything besides water? **If YES:** What type of drink? ____	☐	☐	☐
4. Does your child eat between meals? **If YES:** What does he/she eat? ____ When? (times of day) ___________________ How often? ____________	☐	☐	☐
5. Does your child have a dentist?	☐	☐	☐
6. Have you had your child's teeth checked by a dentist or medical provider? **If YES:** When? _________ By whom? _____________________________________	☐	☐	☐
7. Does your child have cavities or pain in his/her mouth?	☐	☐	☐
8. Do you have concerns about his/her teeth or mouth?	☐	☐	☐

If you are pregnant, answer the following questions:

	Yes	No	NA
1. Do you brush your teeth? **If YES:** Times per day _________ Times of day _________ Days per week _________	☐	☐	☐
2. Do you drink anything but water between meals and snacks? **If YES:** What do you drink? _________________________How often? ___________	☐	☐	☐
3. Do you eat between meals? **If YES:** What? ____ When? (times of day) ____________________ How often? ____________	☐	☐	☐
4. Do you have a dentist?	☐	☐	☐
5. Have you seen the dentist during your pregnancy?	☐	☐	☐
6. Do you have cavities or pain in your mouth?	☐	☐	☐
7. Do you have concerns about your teeth or mouth? **If YES:** What? ____	☐	☐	☐

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