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.)

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? ______________________________

If YES: 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:

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? ______________________________

If YES: 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? ______________________________