Cambridge FAMILY DENTAL

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Child's name: ______________________________ (To be completed by parent/guardian for child under the age of 13)

1. How often are the child's teeth brushed? ______________
   Does an adult assist the child with brushing? Yes or no ___________

2. Has flossing been introduced? Yes or no ___________

3. What are potential sources of fluoride for the child:
   Does your home have fluoridated water? Yes or no ___________
   Fluoridated bottled water? Yes or no ___________
   Prescribed fluoride tablets? Yes or no____________
   Fluoridated vitamins? Yes or no ___________
   Fluoridated toothpaste? Yes or no____________
   Fluoridated rinses? Yes or no____________
   Does the child attend daycare and/or school? Yes or no____________
   Any other potential sources of fluoride?
   ____

4. Do you have any specific concern or question regarding your child's teeth?
   ____

5. How many in-between meals snacks does your child consume? __________What type of snack is typical (ex. Candy, fruits, cheese, etc)? _____________________
   ____

6. What beverages does your child consume? (circle all that apply)
   Pop
   Sports drinks/Energy drinks
   Juice
   Milk
   Water
   Other_____________

7. Does your child currently or have a history of thumb/finger sucking? Yes or no
   Pacifier use? Yes or no

8. Was (or is) your child put to bed with a bottle containing anything other than water? Yes or no ___________

Signature of Parent/guardian___________________________________Date____________