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 _____