KANSAS CITY PEDIATRIC DENTISTRY

NEW CHILD SCREENING

ONLY FOR CHILDREN 4 YEARS OF AGE AND UNDER

CHILD'S NAME: _____ DATE OF BIRTH: _____ DATE: _____

Please answer each of the following questions concerning your child and BRING TO FIRST EXAM APPT.

What age did your child first get teeth?	Before 6 mon.	6-12 mon.	After 12 mon.	
Have parents or siblings had cavities?	Yes	No		
Who brushes your child's teeth?	Parent	Child	No One	
What type of toothpaste is used for your child?	Fluoride	No Fluoride	Don't Know	None
Who flosses your child's teeth?	Parent	Child	No One	
Does your child cooperate for brushing/flossing?	Yes	No		
Is your water fluoridated?	Yes	No	Don't Know	
Does your pediatrician place fluoride?	Yes	No	Don't Know	
Do you use bottled water?	Yes	No		
What oral habits does your child have?	None	Thumb	Pacifier	Finger
When and how often does this habit occur?	All Day	Nap Time	Bed Time	Stress Time
Does your child drink from a:	Regular Cup	Sippy Cup	Bottle	
What liquid does your child mostly drink?	Water	Milk	Juice	Other
Does your child eat between meals?	No	Occ.	Frequently	
Does your child drink between meals?	No	Occ.	Frequently	
Is your child breast fed?	Yes	No	Formula	
Does your child sleep well?	Yes	No		
Does your child snore?	Yes	No	Don't Know	
Have parents or siblings had braces?	Yes	No		
Has your child had any injuries to their mouth?	Yes	No		

What age and severity _____

_____

Does your child take any medications? Yes No

If so, what medications and why _____

_____

What are your special concerns? _____

_____