KANSAS CITY PEDIATRIC DENTISTRY

NEW CHILD SCREENING

ONLY FOR CHILDREN 5 YEARS OF AGE AND ABOVE

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

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

Has your child had cavities in the past?	Yes	No	Don't Know	
Does your child currently have cavities?	Yes	No	Don't Know	
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	
Is your water fluoridated?	Yes	No	Don't Know	
Do you use bottled water?	Yes	No		
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	
Does your child sleep well?	Yes	No		
Does your child snore?	Yes	No	Don't Know	
Does your child grind their teeth?	Yes	No	Don't Know	
Have parents or siblings had braces?	Yes	No		
Does your child play sports?	Yes	No		
Does your child wear a mouthguard?	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?	_____			
	_____			