Patient Name:

3. When does your child brush his/her teeth? Morning Between Meals Bedtime Y N 4. Does your child currently use a bottle or breast feed? At what age did the child stop? mos. Y N 7. Does your child floss? N 8. What type of water sources do you use? City N 5. Does your child use a sippy cup between meals or at night? S. Does your child consume any of the following on a daily basis: (check all that apply) Soda Chocolate/Strawberry Milk Juice Sweet Tea Chips Crackers/Dry Cereal Candy/Gum Y N 10. Does your child suck a thumb or finger, use a pacifier, chew on fingernails or other materials?	2. First dental visit? If no, when was the last visit & with whom? 3. When does your child brush his/her teeth? Morning Between Meals Bedtime Y N 4. Does your child currently use a bottle or breast feed? At what age did the child stop? mos. Y N 5. Does your child use a sippy cup between meals or at night 8. What type of water sources do you use? City Well Bottled Other 9. Does your child consume any of the following on a daily basis: (check all that apply) Soda Chocolate/Strawberry Milk Juice Sweet Tea Chips Crackers/Dry Cereal Candy/Gur Y N 10. Does your child suck a thumb or finger, use a pacifier, chew on fingernails or other materials? 11. Name of child's pediatrician/physician: Phone #	
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Y N 27. Leukemia, cancer, or tumors		
28. Is there anything else we should know while treating your child?		_
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X Signature Date Your Relationship to the Child	Signature Date Your Relationship to the Child	
Chaff Nahaa	Chaff Nahaa	
Staff Notes:	Stall Notes:	