Spring Lake Dental Group
David G. Dickerhoff, DDS
& Associates, PA

Child's Name: ______________________________ **Age:** __________ **Date:** ________________

This is a questionnaire that will help our health care professionals properly assess your child's current health status. Please take a moment to provide us with information that will enable us to help your child achieve optimum oral health.

Approximately when was your child's last dental cleaning? __________________________

Who brushes your child's teeth? _____________________________

Does your child spit or swallow the toothpaste? Spit Swallow

Does your child floss? (Y) (N) How often?________________ Independently? (Y) (N)

Does your child use any other dental aides? Circle those that apply.

Toothpicks	Floss threaders	Disclosing tablets
Reach flosser	Disposable flossers	Xylitol chewing gum
Fluoride tablets	Sensitivity toothpastes	Prescription toothpastes

Does your child use mouthwash? (Y) (N) If so, what brand is it?__________________

What brand of toothpaste does your child use?________________________

What type of toothbrush does your child use? Manual Electric Sonic

If you answered 'manual', are the bristles? Hard Medium Soft I don't know

Are there any dexterity problems with the use of your child's hands? (Y) (N)

What is the major water source for your child? (please select one)

_____Public water supply _____Private well _____Bottled water _____Filtered at refrigerator or sink

Does your child drink from a 'sippy' cup? (Y) (N) or take a 'sippy' cup or any drink to bed? (Y) (N)

Has your child ever worn braces? (Y) (N)

If so, does he/she currently wear retainers? (Y) (N) Are they for the: Top Bottom Bonded in

Are you interested in talking about possible orthodontics (braces)? (Y) (N)

Does your child play any contact sports? (Y) (N) If so, what?_________________________________

Is there any history of trauma to your child's head/neck/mouth? (Y) (N)

Do your child clench or grind his/her teeth? (Y) (N)

Does your child have any finger or thumb habits? (Y) (N)

In respect to dental anxiety or fears about being treated in a dental office, where would you rate your child's anxiety on a scale of 1 to 10 with ten being extremely frightened and uncomfortable? _________________

Do you have any concerns about the potential use of nitrous oxide conscious sedation (laughing gas) with your child? (Y) (N)

Can you give us any information that may help us to establish a nice rapport with your child (nicknames, hobbies, interests)?

____

Do you have a problem or issue that you would like addressed today? If so, what is it?

____

Please feel free to ask any question that may allow you to become comfortable with our recommendations for your child's care. We appreciate you choosing our dental office for your family's dental care.