The Care of Your Child's Teeth at Home

Please note- No dentist will be present for this appointment and the dental hygienist is not permitted to diagnose the health of your child's teeth and gums.

Beth Noel RDH/Oral Health Access Supervision Program

Child Name: _____ DOB: _____

Has your child had a dental check-up in the last 6 months? Yes ____ No ____

1. Do you have any concerns about your child's teeth or mouth? □ Yes □ No
   If yes, what concerns do you have? _____
2. On a scale of 0 (no pain) to 10 (extreme pain), how much pain is your child having?
   Teeth 0 1 2 3 4 5 6 7 8 9 10
   (Do not count teething pain)
   Gums/mouth 0 1 2 3 4 5 6 7 8 9 10
3. Does your child have any habits at home? □ Pacifier □ Finger/thumb sucking habit □ Grinding teeth □ Breast-feeding □ Baby bottle □ Sippy cup
   □ Other _____
4. Has your child had: □ Injuries to his/her teeth or mouth □ Toothaches/pain □ Abscess/gum boils □ other kinds of sores anywhere in the mouth
   Explain _____
5. Has your child had any bad/fearful dental or medical experiences? □ Yes □ No
6. Does anyone help clean/brush your child's teeth or gums? □ Yes □ No

   <u>If your child's teeth are brushed</u>,
   a. Who brushes the teeth and gums? □ Caregiver □ Child □ Both □ Other
   b. How often are your child's teeth brushed? □ Never □ Weekly □ Most day □ Once a day □ Multiple Times a Day
   c. What time of day are the child's teeth brushed? □ Morning □ Afternoon □ Bedtime □ Teeth not getting brushed
   d. Does your child cooperate? □ Yes □ No □ Sometimes
   e. What type of toothpaste is used? □ None □ Fluoride/"Anti-cavity" □ Non-fluoride/"Safe to Swallow"/Training toothpaste

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7. Source of drinking water: □ Tap water □ Bottled water with fluoride ("nursery water") □ Bottled water without fluoride (spring/purified water) □ Well water □ Reverse osmosis

8. Does your child drink anything other than water at naptime and/or at night after brushing (includes breast-feeding)? □ Yes □ No
   If yes, what does your child drink? _____

9. Does your child use a bottle, sippy cup, or regular cup with a drink other than water? □ Yes □ No
   If yes, what type of drinks? □ Formula □ Milk □ Chocolate milk □ Juice □ Pop □ Tea □ Gatorade □ Kool-Aid □ Other _____

10. What type of snacks does your child eat in between meals? □ Fruit □ Starchy (crackers, chips) □ Dairy (cheese, yogurt) □ Meats or nuts □ Vegetables □ Sugary or candy □ Other _____

    Number of times a day your child snacks? □ 1-2 □ 3-4 □ more than 4

11. Does the primary caregiver get regular dental checkups? □ Yes □ No

12. Does the primary caregiver have new or recent cavities? □ Yes □ No □ Don't know

13. Do the siblings have new cavities? □ Yes □ No □ Don't know