New Child Questionnaire (Ages 0-6)

Name: _____ DOB / _____ / _____

- **Does your child use a pacifier or is she/he a thumb sucker?**
  _____
- **Full term or premature birth? _____**
- **What approximate age did your child start cutting his/her first tooth? _____**
- **Has your child ever sustained trauma to his/her teeth/face? If so what age?**
  _____
- **What does your child like to drink throughout the day? _____**
- **Does your child go to bed with a bottle or cup? _____**
- **Does your child frequently snack throughout the day? If so, what types of snacks?**
  _____
- **What type of toothpaste does your child use? _____**
- **What type of toothbrush is your child using? Electric or Manual**
- **Are you still helping your child brush? _____**
- **Is your child using any other oral hygiene products (i.e. mouth rinse, etc)?_____**
- **Do you have any dental concerns for your child?**
  _____

Signature of Parent/Guardian **Date**