D E N T I S T R Y I N F R I S C O
C A T H E R I N E K O O , D . D . S .
GENERAL & COSMETIC DENTISTRY

Child Questionnaire

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Child's Name   Age

1. Does your child brush twice daily in the AM and before bed? Yes or No
2. Does the patient floss daily? Yes or No
3. Does an adult aid with the brushing and flossing? Yes or No
4. Does the patient swallow the toothpaste? Yes or No
5. Is the toothpaste fluoridated? Yes or No

6. FLUORIDE: What is the patient's main drinking water? TAP WATER, FILTERED TAP WATER or BOTTLED WATER.

7. Does the patient have any parafunctional habits like thumbsucking, grinding or clenching their teeth, sucking on lemons, chewing ice?_______________ ____
8. Does the patient drink or eat continuously throughout the day or night? Yes or NO
9. Does the patient's diet include raisins, fruit rollups, fruit wrinkles, lollipops, gum or similar sticky, sugary snacks? Yes or No

10. Does the patient play impact sports? Yes or No. If yes, what kind of mouth guard does the patient wear?_______________________________________

Do you have any questions for the dentist regarding the patient?
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Parent or Guardian's Signature   Date