HARBOR COUNTRY DENTAL
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PreVisit Caries Risk Assessment
Parent Questionnaire (for parent to complete on patients ages 0-12 years)

Patient's Name: _____ Age: _____

Please take a few minutes to answer some questions regarding your child's oral health.

1.	Does your child have oral health issues?	Yes	No
2.	Do you have any questions or concerns about your child's teeth or mouth?	Yes	No
3.	Does your child have special health care needs?	Yes	No
4.	Does your child have a dental home (a place where he or she can go for any dental care?	Yes	No
5.	Has your child had a dental visit in the past 6 months? If yes, please specify the date of last dental visit: _____ What is the name of your dentist: _____	Yes	No
6.	Has your child ever had a cavity? If so, has it been treated?	Yes	No
7.	Have you (mother or primary caregiver) had a cavity in the past 12 months?	Yes	No
8.	Does your child drink sugary drinks (including soda pop, flavored water, sports drinks, juice, energy drinks, etc.) most days of the week?	Yes	No
9.	Does your child eat foods that stick to their teeth such as sticky candy, raisins, etc., most days of the week?	Yes	No
10.	Does your child drink fluoridated water or take fluoride supplements most days of the week?	Yes	No
11.	Do you brush your child's teeth twice daily with toothpaste that has fluoride?	Yes	No
12.	Has your child had a fluoride varnish treatment in the past 6 months?	Yes	No
13.	Does your child wear a mouth guard when playing in sports or other activities?	Yes	No
14.	Do you floss your child's teeth if there are at least two teeth touching?	Yes	No
For family with children under 3 years of age:			
15.	Does your child sleep with a bottle?	Yes	No
16.	Does your child breastfeed throughout the night?	Yes	No
17.	Does your child use a bottle or sippy cup containing drinks other than water?	Yes	No