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Pediatric Dentistry & Orthodontics
Where smiles start.

Pediatric Dentistry
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Orthodontics
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Oral Health Risk Assessment

CHILD'S NAME _____ **AGE** _____

CHILD'S HEALTH HISTORY:

	PLEASE CIRCLE	
Did birthmother have any problems during pregnancy?	Y	N
Was child premature?	Y	N
Were there any complications during birth?	Y	N

If Yes to any of the above, explain _____

PARENT'S DENTAL HISTORY:

Mother: Do you receive regular dental care?	Y	N
Have you ever had dental decay?	Y	N
Father: Do you receive regular dental care?	Y	N
Have you ever had dental decay?	Y	N

DIET AND NUTRITION:

Is/was your child breastfed?	Y	N
Does your child sleep with a bottle?	Y	N
Does your child drink juice or sugar sweetened beverages?	Y	N

How many meals/snacks does your child eat per day? _____

ORAL HYGIENE:

Do you brush your child's teeth/gums?	Y	N

If Yes, how often _____

Do you use fluoride toothpaste to clean your child's teeth?	Y	N

FLUORIDE:

Does your child drink tap water?	Y	N
If yes, is the water filtered?	Y	N
Does your child drink bottled water?	Y	N
If yes, is it fluoridated?	Y	N

PARENTS SIGNATURE _____ **DATE** _____