Grandville
Family Dental Care, P.C.

Pediatric Risk Assessment

Child's Name _____ Date _____
Child's Age _____ Birth Date _____

To help us assess your child's dental needs, please answer the following questions. Thank you.

	YES	NO
Health History		
Did birth mother have any problems during pregnancy?	_____	_____
Has your child needed frequent use of liquid medication?	_____	_____
Has the parent(s)/caretaker seen a dentist in the last year?	_____	_____
Notes: _____		
Diet and Nutrition		
Is/was your child breastfed?	_____	_____
Does/did your child sleep with a bottle?	_____	_____
Does/did your child drink from a sippy cup or cup?	_____	_____
Is your child on a special diet?	_____	_____
Notes: _____		
Fluoride Adequacy		
Do you have well water?	_____	_____
If yes, has the water been tested for fluoride content?	_____	_____
Does your child only drink bottled water?	_____	_____
Notes: _____		
Oral Habits		
Does your child have any oral habits? (pacifier, thumb sucking)	_____	_____
Notes: _____		
Oral Development		
Does your child have teeth?	_____	_____
Child's age (in months) when first tooth erupted? _____		
Has your child experienced teething problems?	_____	_____
Notes: _____		
Oral Hygiene		
Do you clean your child's teeth/gums? Frequency _____	_____	_____
Does your caretaker clean your child's teeth/gums?	_____	_____
Do you use a toothbrush to clean your child's teeth?	_____	_____
Do you use toothpaste to clean your child's teeth?	_____	_____
Notes: _____		

Circle: Mother Father Guardian Signature: _____

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