Pediatric Dentistry of Reston
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NEW PATIENT QUESTIONNAIRE

Patient Name: _____ Patient DOB: _____

Was your child breastfed? Yes, specify how long _____ / No

Was your child bottle-fed? Yes, specify how long _____ / No

Bottle-fed during the night? Yes / No

Does your child regularly drink juice? Yes / No

Does your child regularly drink chocolate milk? Yes / No

Does your child regularly drink milk? Yes / No

Any flavor enhancer (Nestle, sugar, syrups)? Yes, specify _____ / No

Does your child frequently snack? Yes / No

If yes, what snack is the most frequent? _____

How many times a day does your child brush his/her teeth?

Never / Once / Twice / After every meal

How many times a day does your child floss his/her teeth?

Never / Once / Twice / After every meal

Does your child receive any fluoride? Yes / No

If yes, how (water supply, toothpaste, etc.)? _____

Does your child have any habits? Yes / No

If yes, what kind (thumb sucking, grinding, pacifier, etc) and how frequent?

_____

_____

Office Use:
Med _____