## **Prenatal Oral Health Information Form**

Patient Name:	DOB: / /
Telephone:	Est. Delivery Date: / /
Tell Us About Your Dental Routi	
Choose the answer that is most similar to your d	ental care routine. A B C
<ul><li><b>1. How often do you visit a dental professional?</b></li><li>a. Once every six months.</li><li>b. Once a year.</li><li>c. Once every few years or never.</li></ul>	<ul> <li>6. Do you smoke or use any tobacco products? (including cigarettes, e-cigarette (vaping) devices or chewing tobacco)</li> <li>a. No.</li> <li>b. Yes, but rarely.</li> <li>c. Yes, regularly.</li> </ul>
<ul> <li>2. How often do you brush your teeth?</li> <li>a. Once or twice a day.</li> <li>b. A couple times a week.</li> <li>c. Not very often.</li> </ul> 3. How do you satisfy your pregnancy cravings? <ul> <li>a. I usually eat healthy food like fruits, vegetables, whole</li> </ul>	<ul> <li>7. What do you do after you experience morning sickness?</li> <li>a. Rinse my mouth out with a baking soda and water solution.</li> <li>b. Brush my teeth and/or rinse with just water.</li> <li>c. Nothing.</li> <li>d. I don't get morning sickness.</li> <li>e. Other. Please describe</li> </ul>
<ul> <li>grains, yogurt or cheese.</li> <li>b. Sometimes I eat healthy things, but I also eat sugary/salty snacks like cookies and chips.</li> <li>c. I mostly eat sugary/salty snacks like cookies and chips.</li> <li>d. Other. Please describe</li> </ul>	<ul> <li>8. Are you experiencing any pain, bleeding or hot/cold sensitivity in your teeth or gums today?</li> <li>a. No.</li> <li>b. A little bit.</li> <li>c. Yes. Please describe</li></ul>
<ul> <li>4. What do you usually drink during the day?</li> <li>a. Mostly water, milk, or other sugar-free beverages.</li> <li>b. Some water and some soda, juice, coffee or tea.</li> <li>c. Mostly soda, juice, coffee, or tea.</li> <li>d. Other</li> </ul>	<ul> <li>9. Have you had any dental work (fillings, extractions, root canals, etc.) done in the past 12 months?</li> <li>a. No.</li> <li>b. Yes. Please describe</li></ul>
<ul><li>5. How often do you floss?</li><li>a. At least once a day.</li><li>b. Every few days or at least once a week.</li><li>c. Not very often or never.</li></ul>	<ul><li><b>10. Do you have dental insurance?</b></li><li>a. Yes.</li><li>b. I don't know.</li><li>c. No.</li></ul>

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