Access to Baby & Child Dentistry™

Family Dental Connections

Date:_____

Client Name: _____

Has a dentist? Yes ___ No ___ Dental needs? Yes ___ No ___

When was your or your child's last dental visit?_____

Child Name: _____ Age: _____ Has a dentist? Yes ___ No ___

Child Name: _____ Age: _____ Has a dentist? Yes ___ No ___

Child Name: _____ Age: _____ Has a dentist? Yes ___ No ___

Child Name: _____ Age: _____ Has a dentist? Yes ___ No ___

Child Name: _____ Age: _____ Has a dentist? Yes ___ No ___

ABCD and DentistLink info/resources provided? Yes ___ No ___ N/A ____

Dental education provided? Yes _____ No _____

Follow-up:

Has the parent scheduled a dental appointment? Yes _____ No _____

If yes, list the clinic and appointment date:_____

If applicable, list barriers to accessing care:

_____

_____

Additional support needed: Yes ___ No ___

If yes, refer to ABCD Coordinator. Date of referral:_____

Motivational interviewing suggestions to the parent:

Tell me about your dental experience growing up.

What comes to mind when you hear the word "dentist"?

What do you envision your child's dental experience to be like?

What role do you think you play in shaping their experience?

Tell me what you know about oral hygiene.

Do you want to avoid dental pain for your child?

Share ways you can help your child stay pain free (for example — brushing regularly, dental visits, healthy eating)

Thank you for being a proactive parent and connecting your child to a dentist.

CLARK COUNTY WASHINGTON PUBLIC HEALTH

For other formats, contact the Clark County ADA Office
564.397.2322 / 711 or 800.833.6388 /ADA@clark.wa.gov

July 2025