Do You Need Fluoride?

Patient Name: ____

Please put a **CHECK** in front of any of the statements that apply to you. This will aid us in determining your individual need for a specific ***fluoride therapeutic program*** that will help you keep your teeth for life!

- No fluoride in your drinking water as a child
- No fluoride in your drinking water now
- Drink filtered or bottled water
- Have receding gums or history of gum disease
- Have multiple fillings and/or crowns
- Strong family history of dental decay
- Mouth feels dry; take medications that cause dry mouth; or breathe through your mouth
- Currently wear orthodontic braces
- Have sensitivity to hot, cold or touch
- Use home whitening products
- Have limited hand dexterity
- Use chewing gum, lozenges or hard candy with sugar between meals
- Visit dental office irregularly
- Currently undergoing (or history of) chemotherapy or radiation therapy
- Suffer from acid reflux
- Teeth that just don't feel clean or trap food
- Snack frequently between meals
- Sip on beverages throughout day (other than water)
- Use tobacco products of any type
- Grind teeth frequently
- Floss less than once per day