



# Getting to Know Me

## Information for Your Dental Office While You Are Pregnant

*Please fill out this form about yourself. The information you give will help the dental office staff understand and meet your needs. Bring it with you to your dental appointment.*

My name: \_\_\_\_\_ My age: \_\_\_\_\_

I'm \_\_\_\_\_ weeks pregnant My baby's expected due date is: \_\_\_\_\_

My last dental visit was:  6 months ago  12 months ago  more than 12 months ago  
 I can't remember

I'm receiving prenatal care:  Yes  No The name of my prenatal care provider and their office phone number are: \_\_\_\_\_

I do the following things to take care of my mouth and teeth: \_\_\_\_\_

I have the following questions about taking care of my mouth and teeth: \_\_\_\_\_

During my pregnancy, I've experienced the following things:

- |   |  |
|---|--|
| <input type="checkbox"/> Bad taste in my mouth        | <input type="checkbox"/> Morning sickness (nausea, vomiting, gastric reflux) |
| <input type="checkbox"/> Swollen and/or bleeding gums | <input type="checkbox"/> Toothaches/pain/swollen face                        |
| <input type="checkbox"/> Gagging when brushing        | <input type="checkbox"/> Other, please specify: _____                        |
| <input type="checkbox"/> Loose teeth                  |  |

During this pregnancy, I:  smoke  vape  drink alcohol

During this pregnancy, I feel the best during these times of the day: \_\_\_\_\_

This resource is supported by the Administration for Children and Families (ACF) of the United States (U.S.) Department of Health and Human Services (HHS) as part of a financial assistance award totaling \$8,200,000 with 100% funded by ACF. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement by, ACF/HHS or the U.S. Government.



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