Supplementary Materials

Table S1. School questionnaire.

Child personal information

Name	
Surname	
Date of birth	
Sex	
Place of Residence	

Mother's medical history

Born in Italy	□ yes □ no
Place of Residence	
Weight	
Height	
Level of Education	□ no education □ primary □ secondary □ high school graduate □ undergraduate □ postgraduate (master/doctorate)
Do you smoke?	□ yes □ no
If YES, how many cigarettes a day?	
How many times a year do you visit your dentist?	□ never □ one □ two □ more than two
Have you ever had dental caries on your permanent teeth?	□ yes □ no
Have you ever extracted your teeth because of caries?	□ yes □ no
When have you last visited your dentist?	□ less than 6 months □ more than 6 months □ more than a year
How many times a day do you brush your teeth?	□ never □ one □ two □ more than two
Did you take fluoride during pregnancy and/or feeding?	□ yes □ no

Father's medical history

Born in Italy	□ yes □ no
Place of Residence	
Weight	
Height	
Level of Education	□ no education □ primary □ secondary □ high school graduate □ undergraduate □ postgraduate (master/doctorate)
Do you smoke?	□ yes □ no
If YES, how many cigarettes a day?	
How many times a year do you visit your dentist?	□ never □ one □ two □ more than two
Have you ever had dental caries on your permanent teeth?	□ yes □ no
Have you ever extracted your teeth because of caries?	□ yes □ no
When have you last visited your dentist?	□ less than 6 months □ more than 6 months □ more than a year
How many times a day do you brush your teeth?	□ never □ one □ two □ more than two
How many members are there in your family?	□ 1 □ 2 □ 3 □ 4 □ 5 □ >5

Child's medical history

Was he/she delivered at term?	□ yes □ no
Was he/she breastfed?	□ yes □ no How many months?
Was he/she fed with formula?	□ yes □ no How many months?
Has the child ever taken fluoride?	□ yes □ no

If YES, up to what age?	
Have you ever been informed about your child's oral hygiene?	□ yes □ no
How many times a day do you think you should brush your teeth?	□ 1 □ 2 □ 3 □ >3
How many times a day does your child actually brush his/her teeth?	□ 1 □ 2 □ 3 □ >3
Does he/she use a toothpaste with fluoride?	□ yes □ no
Does he/she use dental floss?	□ yes □ no
Does he/she use an electric toothbrush?	□ yes □ no
Did he/she use a pacifier?	□ yes □ no
If YES, up to what age?	
Do/did you usually put your child's pacifier in your mouth?	□ yes □ no
Do/did you usually drink from your child's same bottle and/or glass?	□ yes □ no
Do/did you usually use a honeyed pacifier for your child?	□ yes □ no
Does/did your child usually drink or suck something else other than water before sleeping?	□ yes □ no
Does/did your child use diuretics, mucolytics, cough suppressants, bronchodilators, sprays for asthma?	□ yes □ no
Does your child often stay with his/her mouth open?	□ yes □ no
Does your child suffer from allergies?	□ yes □ no
If YES, to what?	
How many times a day does your child eat?	□ 1 □ 2 □ 3 □ 4 □ 5 □ >5
Does he/she eat at night?	□ yes □ no
When was his/her last dental visit?	□ less than 6 months □ more than 6 months □ more than a year

Table S2. Dental clinical record.

Patient's Name and Surname			Date of Birth:
DENTAL GENERAL INFORMATION			
SEX	F	M	
AGE		Years, months	
WEIGHT		Kg	
HEIGHT		cm	
PRESENCE OF CARIES	YES	NO	
NUMBER OF DECAYED TEETH			