

Bridging the Gap Between Knowledge and Practice: Determinants of Parental Behavior in Children's First Dental Visit in Indonesia

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Abstract

Background

Despite recommendations for early dental visits, the utilization of preventive dental services among young children remains low. Early childhood caries continues to be highly prevalent, reflecting a gap between preventive knowledge and actual service uptake. This study aimed to examine parental determinants of children's first dental visit and to explore the gap between knowledge and utilization of preventive dental care.

Methods

A hospital-based cross-sectional study was conducted among 103 parents attending a child development clinic at a provincial referral hospital in Indonesia. Data were collected using a structured questionnaire assessing sociodemographic characteristics, knowledge, perceived barriers, and experiences related to children's first dental visit. The primary outcome was dental service utilization, defined as whether the child had ever visited a dentist. Bivariate analyses and multivariable logistic regression were performed.

Results

Most children had never visited a dentist (74.8%), and among those who had, the first visit was generally delayed until 3–6 years of age. Although parental knowledge regarding early dental visits and preventive care was high, it was not associated with service utilization. Child age was the strongest predictor of dental attendance (OR = 2.13; 95% CI: 1.37–3.32; $p = 0.001$), indicating delayed, problem-driven care-seeking behavior.

Conclusion

There is a sizable difference in the amount of information that people know about their child's dental care and how often they use preventive dental services. Young children are primarily getting traditional dental care which reacts to children's needs instead of providing preventive services.

1. Introduction

Early childhood caries (ECC) remains one of the most prevalent chronic conditions affecting children worldwide, particularly in low- and middle-income countries. Beyond oral health, ECC significantly impacts children's growth, nutrition, and quality of life.^{1,2} Despite being largely preventable, its global burden remains high, reflecting a gap between preventive potential and real-world practice.³ The first dental visit,

recommended within the first year of life by the American Academy of Pediatric Dentistry, serves as cornerstone of preventive care by enabling early risk assessment, parental education, and timely intervention.^{4,5} In addition, early exposure to the dental environment can foster positive experience and reduces anxiety about dental treatment later in life.⁶

Despite these recommendations, a substantial gap remains between parental knowledge and actual practices.^{7,8} Although many parents are aware of the importance of preventive dental care, children are often taken to the dentist only when symptoms such as pain or obvious dental problems arise.⁸⁻¹¹ This gap reflects a disconnect between knowledge and practice—knowledge does not necessarily translate into action. Children's first dental visit are often postponed beyond the recommended age. This action leads to limiting early prevention opportunities and increasing the risk of developing dental issues.^{6,12} This phenomenon suggests that increasing knowledge is insufficient to change behavior. Other underlying factors play a crucial role in influencing parents' decisions regarding their children's oral health.⁷

Parents' decisions about when to take their child for their first dental checkup are not solely based on knowledge. Rather, it involves complicated interactions of cognitive, emotional, and environmental variables.^{13,14} As the principal caregivers, a parent does significantly influence when and if they seek preventive dental care for their child. Other factors that were identified in a prior study include the parents' awareness of the need for early visits, their perception of the vulnerability and severity of dental problems, emotional factors such as dental anxiety, accessibility to dental services, and social influences from the family and community.^{13,15} These factors can be understood using behavioral models such as the health belief model. The model emphasizes the importance of perceived benefits, perceived barriers, and motivators for health-related behaviors.¹⁶ Even when parents are aware of professional advice, perceived barriers—such as concerns about their child's emotional reaction, worries about cost, or limited pediatric dental resources—may outweigh the perceived benefits. The later leads to delayed or missed dental checkups.^{11,17}

Early childhood caries remains prevalent in Indonesia. The ECC highlights the ongoing challenges in the popularization of preventative dental care. National studies indicate a heavy caries burden on children, with a significant proportion going untreated.¹⁸ Recommendations for early dental visits is well established from couple of years earlier, but utilization of these services remains largely problem-driven. The reason is that many children only seek dental treatment when symptoms appear.¹³ Previous local research has shown that children's first dental visit is often late, typically between 5 and 7 years of age, well beyond the recommended age range.¹⁹ This delay suggests systemic deficiencies in preventive care and underscores the need for a better understanding of the underlying factors influencing parental decisions. To date, comprehensive research in Indonesia on the determinants of parental behavior and the knowledge and practice gaps regarding early dental visits, particularly in specific clinical settings, is scarce.

This study was conducted at a regional pediatric developmental clinic, which provides a unique and clinically significant perspective on parental priorities regarding health policy. Children presenting at the clinic often presented with a range of developmental, behavioral, or medical issues. All the conditions which could lead parents to prioritize these issues over oral health prevention. For example, while oral health plays an essential part in general health-research shows us that parents often overlook their child's oral health. Thus, the environment offers an opportunity to learn about how parents prioritize different aspects of their child's health in their decision-making process regarding early dental care. Pediatric developmental clinics also offer a potentially underutilised venue for combining oral health promotion and regular paediatric practice. Current literature offers a poor understanding of how parents feel about dental visits for their children and how they behave when scheduling a child's first appointment at a developmental paediatric clinic in lower-middle-income nations.

Given the current knowledge-practice gap and limited evidence on early childhood developmental health based on referrals, this study aimed to investigate the discrepancy between parents' perceptions and actual behaviors regarding their children's first dental visit. Specifically, this study aimed to identify key factors influencing parental decisions, including cognitive, perceptual barriers, and past experiences.

2. Methods

2.1 Study design and setting

This study employed a hospital-based cross-sectional design. The study was conducted at the Child Development Clinic of Dr. Hasan Sadikin General Hospital, Bandung, Indonesia, a provincial referral hospital. Data collection was done from May to June 2025.

2.2 Participants and sampling

The study population consisted of parents or primary caregivers accompanying their children to the Child Development Clinic during the study period. Participants were recruited using a consecutive sampling method. Parents who were willing to participate and able to complete the questionnaire were included. Incomplete responses were excluded from the analysis.

2.3 Study variables

Data collected included parental and child sociodemographic characteristics, as well as responses to a structured questionnaire on children's first dental visit. Parental variables included age, sex, educational level, and occupation. Educational level was categorized as elementary school, junior high school, senior high school, undergraduate degree, and postgraduate degree. Occupation was categorized as unemployed, civil servant, private employed, and self-employed. Child-related variables included current age, sex, and age at first dental visit, which categorized as < 1 year, 1–2 years, 3–4 years, 5–6 years, and never visited. The primary outcome of this study was parental behavior regarding the child's first dental visit, operationalized as whether the child had ever visited a dentist (yes/no).

2.4 Questionnaire and measurement

Data were collected using a structured questionnaire consisting of demographic information and items assessing parental perception related to the child's first dental visit. The questionnaire contain domains on knowledge, perceived barriers, perceived benefits, and experience-related factors.

The knowledge questions related to parental knowledge of the recommended timing for the first dental visit and their knowledge of the importance of preventive dental care. Barriers were classified as perceived barriers, including beliefs about the child's age, not having symptoms in the child, fear of going to the dentist, problems accessing a dentist, and social influences; and perceived benefits, including beliefs about preventing problems and detecting them early, as well as long-term health benefits. The experience questions related to parental feelings and emotions, the child's behaviour and perceptions of being ready to visit the dentist.

Items were measured using a Likert scale, with higher scores indicating stronger agreement. Because the questionnaire used a branching structure, items in section A were answered only by parents whose children had already attended a dental visit, whereas items in section B were answered only by parents whose children had never attended a dental visit. Therefore, section-specific items were analyzed within their respective subgroups and were not pooled across the full sample.

The questionnaire had previously undergone validity and reliability testing in a pilot sample of 96 respondents. All item demonstrated acceptable validity (factor loading > 0.30), and internal consistency (Cronbach's alpha = 0.72).

2.5 Data collection procedure

Eligible participants were approached during their visit to the clinic and invited to participate in the study. After providing informed consent, respondents completed the questionnaire. Data were collected anonymously and recorded for analysis.

2.6 Statistical analysis

Data were analyzed using descriptive and inferential statistics. Categorical variables were presented as frequencies and percentages. Continuous variables were summarized using means and standard deviations or medians and interquartile ranges, as appropriate.

For the main analysis, the outcome variable was whether the child had ever visited a dentist. Association between the outcome and independent variables, including parental sociodemographic characteristics and selected perception-related variables, were assessed using the chi-square test or Fisher's exact test.

Variables with $p < 0.25$ in the bivariate analysis, or those considered clinically relevant, were included in a multivariable logistic regression model to identify independent determinants of dental visit behavior.

Results were reported as odd ratios (Ors) with 95% confidence intervals (CIs). A p-value < 0.05 was considered statistically significant.

Subgroup analysis were performed separately for parents whose children had never visited a dentist (to explore perceived barriers) and for those whose children had already attended a dental visit (to assess experiences and perceived benefits).

3. Result

3.1 Sociodemographic characteristics of respondents and children

A total of 103 parents participated in this study (Table 1). The majority of respondents were female (80.6%), while male respondents accounted for 19.4%. The mean parental age was 33.02 ± 7.74 years, ranging from 19 to 57 years. Most parent respondents were high school graduates (53.4 %), followed by college graduates (23.3 %), Junior High School (17.5 %), and Elementary School (5.8 %). In terms of occupation, a large number of respondents were either not formally employed or were homemakers (65.0 %), while a smaller percentage of respondents were working in the private sector (14.6 %), working for themselves (14.6 %), and working in the public sector (5.8 %). Among the children, the distribution of sex was relatively balanced, with 52.4% boys and 47.6% girls. The mean age of the children was 3.59 ± 1.78 years, with an age range of 1 to 6 years.

Table 1. Sociodemographic characteristics of the respondents and children (n = 103)

Variable	n	%
Parental sex		
Male	20	19.4
Female	83	80.6
Parental age, years		
Mean ± SD	33.02 ± 7.74	
Range	19–57	
Educational level		
Elementary school	6	5.8
Junior high school	18	17.5
Senior high school	55	53.4
University	24	23.3
Occupation		
Unemployed/housewife	67	65.0
Civil service	6	5.8
Private sector	15	14.6
Self-employed	15	14.6
Child's sex		
Boy	54	52.4
Girl	49	47.6
Child's age		
Mean ± SD	3.59 ± 1.78	
Range	1–6	

3.2 Children's dental visit behavior and timing of the first dental visit

Among the children included in this study, the majority had never visited a dentist (74.8%), while only 25.2% had experienced at least one dental visit (Table 2). Among those who had visited a dentist (n = 26), the timing of the first dental visit was generally delayed, with most children attending at 3-6 years of age rather than during the recommended early period.

Table 2. Children's dental visit behavior and timing of first dental visit (n = 103)

Variable	n (%)
Dental visit behavior	
Never visited	77 (74.8)
Ever visited	26 (25.2)
Age at first dental visit (among those who visited, n = 26)	
1–2 years	6 (23.1)
3–4 years	8 (30.8)
5–6 years	12 (46.2)

3.3 Parental knowledge and perceptions regarding the first dental visit

Overall, parental knowledge and perceptions regarding the first dental visit were generally positive (Table 3). The recommendation that children have their first dental visit by the age of one was supported by almost nine out of 10 (87.4%) parents. Furthermore, over eight out of 10 (81.6%) parents agreed that children should be seen by a dentist in the absence of any symptoms. Similarly, most respondents (79.6%) perceived the first dental visit as important. However, perceptions of child readiness were more variable, with only 51.5% of parents considering their child ready for a dental visit. In addition, 79.6% of parents perceived the dental clinic environment as child-friendly.

Table 3. Parental knowledge and perceptions regarding children's first dental visit (n = 103)

Variable	n (%)
Agreement with recommendation for first dental visit by age 1 year (Q8)	
Non-agree	13 (12.6)
Agree	90 (87.4)
Agreement that children should visit a dentist even without symptoms (Q9)	
Non-agree	19 (18.4)
Agree	84 (81.6)
Perceived importance of the first dental visit (Q23)	
Not important	21 (20.4)
Important	82 (79.6)
Perceived child readiness for dental visit (Q25)	
Not ready	50 (48.5)
Ready	53 (51.5)
Perception of dental clinic environment (Q26)	
Unfriendly	21 (20.4)
Friendly	82 (79.6)

3.4 Factors associated with children's dental visit behavior

Bivariate analysis in Table 4 showed that several factors were associated with children's dental visit behavior. There was a statistically significant relationship ($p = 0.034$) between parent age and dental attendance whereby parents of children who had been to the dentist were older on average than parents of children who had not been. There was also a very highly statistically significant association with age of child as it relates to children who visited the dentist ($p < 0.001$). Older children were more likely to have previously made a visit to the dentist compared to younger children.

A parents' occupation was significantly associated with their child's use of dental services ($p=0.049$), whereas the parent's level of education had a borderline association with visit behaviour ($p=0.060$). No statistically significant associations were found between parental sex and child sex ($p=0.263$), nor between parental and child sex ($p=0.534$).

In terms of knowledge and perception variables, the perception of child readiness for a dental visit was significantly correlated with dental attendance ($p = 0.036$), with parents reporting higher rates of readiness for children visiting a dentist than for children who had not yet visited a dentist.

However, no significant associations were observed for agreement with early dental visit recommendations (Q8; $p = 0.176$), agreement with preventive visits without symptoms (Q9; $p = 0.775$), perceived importance of the first dental visit (Q23; $p = 0.464$), or perception of the dental clinic environment (Q26; $p = 0.694$).

Table 4. Factors associated with children's dental visit behavior

Variable	Ever visited n (%)/ distribution	Never visited n (%)/ distribution	p-value
Parental sex			0.263
Male	7 (26.9)	13 (16.9)	
Female	19 (73.1)	64 (83.1)	
Parental age	Higher mean rank (62.73)	Lower mean rank (48.38)	0.034**
Parental educational level			0.060*
Elementary school	2 (7.7)	4 (5.2)	
Junior high school	1 (3.8)	17 (22.1)	
Senior high school	13 (50.0)	42 (54.5)	
University	10 (38.5)	14 (18.2)	
Parent occupation			0.049*
Unemployed/housewives	18 (69.2)	49 (63.6)	
Civil service	3 (11.5)	3 (3.9)	
Private sector	5 (19.2)	10 (13.0)	
Self-employed	0 (0.0)	15 (19.5)	
Child sex			0.534
Boy	15 (57.7)	39 (50.6)	
Girl	11 (42.3)	38 (49.4)	
Child age	Higher mean rank (76.25)	Lower mean rank (43.81)	<0.001**
Q8: Agreement with recommendation for first dental visit by age 1 year			0.176*
Non-agree	1 (3.8)	12 (15.6)	
Agree	25 (96.2)	65 (84.4)	
Q9: Agreement that a child should visit a dentist even without symptoms			0.775*
Non-agree	4 (15.4)	15 (19.5)	
Agree	22 (84.6)	62 (80.5)	
Q23: Perceived importance of first dental visit			0.464

Not important	4 (15.4)	17 (22.1)
Important	22 (84.6)	60 (77.9)
Q25: Perceived child readiness for dental visit		0.036
Not ready	8 (30.8)	42 (54.5)
Ready	18 (69.2)	35 (45.5)
Q26: Perception of dental clinic environment		0.694
Unfriendly	6 (23.1)	15 (19.5)
Friendly	20 (76.9)	62 (80.5)

* Fisher's exact test (2-sided)

**Mann–Whitney U test.

3.5 Multivariable analysis of factors associated with children's dental visit behavior

Multivariable logistic regression analysis was performed to identify independent factors associated with children's dental visit behavior (Table 5). The results showed that child age remained the strongest predictor of dental attendance. Each additional year of age was associated with more than a twofold increase in the likelihood of having visited a dentist (OR = 2.13; 95% CI: 1.37–3.32; $p = 0.001$).

Parental educational level was also significantly associated with dental visit behavior (OR = 0.24; 95% CI: 0.06–0.96; $p = 0.044$), indicating differences in care-seeking patterns across educational groups.

In contrast, parental age ($p = 0.799$), parental occupation ($p = 0.285$), and perceived child readiness ($p = 0.118$) were not significantly associated with dental attendance after adjustment for other variables.

Table 5. Factors associated with children's dental visit behavior (logistic regression analysis)

Variable	B	OR (Exp(B))	95% CI	p-value
Parental age	0.010	1.01	0.93 – 1.09	0.799
Child age	0.757	2.13	1.37 – 3.32	0.001
Educational level (high vs low)	-1.411	0.24	0.06 – 0.96	0.044
Occupation (employed vs not)	0.730	2.08	0.54 – 7.92	0.285
Perceived child readiness (ready vs not)	-0.907	0.40	0.13 – 1.26	0.118

3.6 Reasons and perceived barriers among parents whose children had never visited a dentist

Among parents whose children had never visited a dentist (n = 77), the most frequently reported main reason for not attending was the perception that a dental visit was not yet necessary (61.0%). There were a number of other reasons given, but two of the most frequently cited reasons are: not enough time to do it; and might be afraid of going to the dentist. Only a small percentage of respondents cited trouble finding a dentist or concern about the cost as their reason why they could not have dental care for their children.

As far as perceived barriers were concerned, the barriers most frequently reported were fear or discomfort of child (59.7%), no visible dental problems (57.1%) and lack of information (53.2%). Approximately 50% of parents believed their child was too young to go to the dentist (45.5%) with 41.6% preferring to wait until their child was older. Additionally, 39.0% reported difficulty accessing dental services.

Table 6. Reason and perceived barriers among parents whose children had never visited a dentist (n = 77)

Domain	Item	n (%)
Main reason for not attending (single response)	Not yet necessary	41 (61.0)
	Child may be afraid	13 (16.9)
	Could not find suitable dentist	3 (3.8)
	No time	17 (21.8)
	Cost concerns	4 (5.2)
Perceived barriers (multiple responses allowed)	Child is still too young	35 (45.5)
	No visible dental problem	44 (57.1)
	Child's fear or discomfort	46 (59.7)
	Lack of information	41 (53.2)
	Prefer to wait until child is older	32 (41.6)
	Difficulty accessing dental services	30 (39.0)

3.7 Experiences and perceived benefits among parents whose children had attended a dental visit

Among parents whose children had attended a dental visit (n = 26), perceptions of the experience and its benefits were generally positive. Most parents reported feeling calm about the visit (61.5%), although only 26.9% reported that their child showed a positive or neutral response.

Every respondent (100%) stated that they were confident their appointment would provide them with reassurance and prepare their children for future dental care. Also, 96.2% of the respondents also said that early visits to the dentist were essential even if the child does not have symptoms already, and that routine check-ups were essential according to 92.3% of the responses.

Table 7. Experiences and perceived benefits among parents whose children had attended a dental visit (n = 26)

Experience/benefit item	n (%) positive/agreeing
Parent felt calm about the visit	16 (61.5)
Child showed positive/neutral response	7 (26.9)
Visit helped prevent future problems	26 (100)
Early visit is important even without symptoms	25 (96.2)
Visit provided reassurance	26 (100)
Early visit helps children adapt to dental care	26(100)
Routine monitoring is important	24 (92.3)

4. Discussion

This study highlights a substantial gap between parental knowledge and the utilization of preventive dental service for young children. Although most parents demonstrated adequate awareness of early dental visit recommendations and the importance of preventive care, the majority of children had never visited a dentist, and those who had attended did so a relatively late age. These findings indicate that knowledge alone is insufficient to translate into service uptake and suggest a persistent disconnect between awareness and preventive health-seeking behavior.²⁰

This study indicates that there is a concern in general public health related to the low number of children using early preventive services; and how early preventive services are not being used despite established guidelines.⁶ Because preventive services are underutilized, there are concerns about using the recommended services from a developmental standpoint. For example, there are professional guidelines for pediatric dentists recommending that children have an established dental home by their first birthday.²¹ Unfortunately, due to underutilization of preventive dental care, many children are not receiving dental preventive services as recommended. Based on the results of this study, it appears that the majority of children's first dental visits occur between the ages of 3 and 6 years, demonstrating that current use of dental services tends to be problem-focused rather than preventative. Therefore, as early dental care continues to be delayed and underutilized, the burden of early childhood caries (ECC) will continue to be compounded by missed opportunities for early risk assessment/early intervention services.³

The study's primary conclusion reveals that the extent of parental understanding and attitudes have a limited impact on children's utilization of dental services. Although parents generally agree that children should have regular dental checkups and receive preventive care, they do not visit the dentist regularly. This finding is consistent with previous research showing the knowledge alone does not necessarily lead to behavior change.²² From a public health perspective, this suggests that improving knowledge without addressing structural and perceptual barriers may have limited impact on service utilization.²³

The Health Belief Model posits that health-related behaviour is shaped by knowledge, perceived barriers, perceived benefits, and cues to action.^{24,25} In this context, the lack of a significant correlation between knowledge and behaviour suggests that alternative factors, especially psychological and contextual determinants, exert a more substantial influence.

Child age emerged as the strongest determinant of dental service use. Older children were significantly more likely to have visited a dentist, indicating that parents tend to delay care seeking until the child is older. This pattern reflects a reactive approach to oral health, where services are utilized only when the child is perceived to be developmentally ready or when problems become apparent.²⁶ Such delayed engagement with dental service underscores a critical gap in preventive care pathways and highlights the need for early-life interventions that encourage timely access to care.²⁷

Although perceived child readiness was associated with dental attendance in the bivariate analysis, this association did not remain significant after adjustment. This finding indicates that perceived readiness may be influenced by child age and may function as an intermediate factor in parental decision making. Parents may delay dental visit until they believe the child can cooperate or tolerate the procedure, which may unintentionally contribute to postponing preventive care.^{28,29} Addressing parental concerns related to readiness and behavior is therefore an important component of strategies aimed at improving early service utilization.

For parents with children who have not yet gone to the dentist, the subgroup analysis provides additional information that explains why there may be barriers to accessing dental healthcare. The most common reason given for not visiting a dentist was that they felt a dentist was not needed, followed by no visible dental problems or concerns about experiencing pain or fear with visiting a dentist. This shows that access to dental care is viewed as a care need rather than as prevention. Moreover, parents believe that their child is too young to go to the dentist, as well as wanting to delay visits further leads them to delay seeking dental healthcare.^{26,27,30} This relates to both the parent's individual perceptions of needing to see a dentist as well as the larger gaps seen in how preventive healthcare is communicated to parents and the way preventive services are integrated.³¹

By contrast, all of the parents who had taken their children to see a dentist thought that the dentist was a great experience for both them and their child, and that the visit was beneficial. They all believed that dentist visits are preventative in nature (e.g., they provide parents with peace of mind, allow for early detection of issues with their child's teeth, and help to ease their children into the idea of going to a

dentist). This suggest that direct experience with dental services can significantly reshape parental perceptions and may act as a facilitator of future preventive behavior.^{32–35} Public health perspectives the highlights of importance early exposure and positive initial encounters with dental care as a strategy to improve long-term service utilization.

Taken together, these findings demonstrate that parental decisions are influenced more strongly by perceived barriers and contextual factors than by knowledge alone. Parents often perceive barriers to accessing dental services before the first dental visit far outweigh the benefits; therefore, parents are less likely to take their children to the dentist as a result of these perceived barriers. Once parents have experienced dental care directly, their perception of the benefits of dental care becomes much clearer, and parent attitudes shift toward preventative care. This pattern is consistent with established models of behavior change. It demonstrates the importance of addressing both the perceptual and experiential aspects of health-related behaviors.^{27,32}

From both a policy and practical standpoint, the results suggest that merely providing educational interventions will likely not result in improvement for early access to dental services for children.^{36,37} Therefore, the focus of public health strategies should be on reducing perceived barriers to dental service access, promoting earlier use of dental services, and incorporating oral health within established pediatric care pathways (such as those provided through the child development clinics that were the basis for this study) as they provide an excellent opportunity to add oral health promotion to pediatric care provided on a routine basis. Anticipatory guidance, family education or counselling, and behaviour change strategies may be powerful tools to aid in addressing parental apprehension regarding their child's readiness for dental care and thus promote the early use of dental services for children.^{38,39}

This study has several strengths, including its focus on a clinically relevant population in referral setting, where competing health priorities may influence parental decision-making. In addition, the integration of knowledge, behavior, barriers, and experiential factors provide a comprehensive understanding of determinants of the first dental visit.

Nonetheless, various constraints must be acknowledged. The cross-sectional design prevents causal inference, and the results rely on self-reported data, which may be influenced by recall and social desirability bias. The limited sample size and single-center context may restrict generalisability. Subsequent research involving larger and more heterogeneous populations is essential to corroborate these findings and investigate intervention strategies.



5. Conclusion

Overall, there is considerable disparity between what parents know about dental hygiene and what they actually do to take care of their child's teeth. There is also an enormous discrepancy in respect to how

old a child is when he/she first sees a dentist, meaning that there is often a substantial delay between when there are problems with a child's teeth and when they seek treatment. Focusing on parents' perceptions, particularly regarding the need for treatment and whether their child is ready to go to the dentist, and creating positive dental visits at an early age will likely be an essential component of improving the use of preventive dental services for young children.

Declarations

Conflict of Interest: The authors declare no conflict of interest.

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