

Patient's Name \_\_\_\_\_

Date \_\_\_\_\_

**To be Completed by Parent or Guardian**

Please circle the most accurate answer for each question.

**Risk Indicators**

- |   |                           |                     |                      |   |
|---|---------------------------|---------------------|----------------------|---|
| 1. Number of times per day that child's teeth/gums are brushed/cleaned  | 0                         | 1                   | 2                    | 3 |
| 2. Number of between-meals snacks or beverages consumed, including juice, carbonated beverages and sports drinks (include use of a bottle or sippy cup with liquid other than water and doses of sweetened medicines) | More than 3 times per day | 1 - 2 times per day | Mealtimes only       |   |
| 3. Fluoride use, including local fluoridated water, vitamins containing fluoride, fluoride supplements and toothpaste with fluoride   | None                      | Toothpaste only     | Toothpaste and more  |   |
| 4. If dental work was necessary, time since child last had a filling  | Less than 1 year          | 1 - 2 years         | More than 2 years    |   |
| 5. Child's parents or brothers/sisters have fillings or cavities  | Yes                       | No                  |                      |   |
| 6. Child wears braces, oral appliances or space maintainers   | Yes                       | No                  |                      |   |
| 7. How often does child routinely visit the dentist (dental home)?  | Less than 1 per year      | 1 per year          | More than 1 per year |   |
| 8. Child has special (physical or cognitive) needs that impact cooperation or oral health care  | Yes                       | No                  |                      |   |
| 9. Is your income a determining factor in bringing your child/family to the dentist?  | Yes                       | No                  |                      |   |
| 10. Does anyone in the household smoke?   | Yes                       | No                  |                      |   |

**Examination - To be Completed by Dentist**

- |  |         |        |
|--|---------|--------|
| 1. Visible plaque  | Present | Absent |
| 2. Gingivitis  | Present | Absent |
| 3. Areas of enamel demineralization                        | Present | Absent |
| 4. Enamel defects, deep pits or fissures                   | Present | Absent |
| 5. Active caries   | Present | Absent |
| 6. Past dental history of decayed, missing or filled teeth | Present | Absent |

Two or more circles in the first column indicates a child is at "High" risk and that word should be circled. One circle in the first column indicates "Medium" risk. Two or more circles in the center column indicate "Medium" risk. Only one circle in the center column is "Low" risk.

Dentist should circle appropriate rating

Dentist's Signature \_\_\_\_\_ Date \_\_\_\_\_

High Medium Low

**CARIES RISK ASSESSMENT**