▫Dental History and Caries Risk Assessment

Patient Name: _____ Date: _____ Age: _____

Name of previous dentist _____ Dentist's phone # _____

Have you had check up x-rays (4 bitewings) within the last year?	**Y N**
Have you had a full mouth series (about 18 x-rays) within the last 5 years?	**Y N**
Have you had deep cleanings or been told you have periodontal disease? If deep cleaning approximate date _____	**Y N**
Do you have missing teeth and want to discuss replacement options?	**Y N**
Number of cavities in the past 3 years: ☐ None ☐ 1-2 ☐ 3+	
*Has anyone in your immediate family had any cavities in the last 3 years?	**Y N**
*Do you frequently consume food or drinks high in sugars or acidic?	**Y N**
*Do you snack often between meals? (> 3 snack periods if under 12, > 1 snack if over 12)	**Y N**
*For young children, do they take a bottle or sippy cup with anything other than water to bed?	**Y N**
*Do you have dry mouth?	**Y N**
*Are you undergoing chemo or radiation therapy?	**Y N**
*Do you currently have braces?	**Y N**
Before today, have you been to a dental office for a check up and cleaning in the last 18 months?	**Y N**
Do you brush your teeth at least 2 times per day?	**Y N**
Do you use a fluoride toothpaste?	**Y N**
Do you floss every day?	**Y N**
Are your teeth sensitive to hot/cold/sweets?	**Y N**
Do you use tobacco?	**Y N**
Do you drink alcohol more than 3 days per week?	**Y N**
Do you have an eating disorder?	**Y N**
For children under 2, are/did they use a bottle or nurse past 14 months old?	**Y N**
Do you use a night or snore guard or a CPAP	**Y N**

Do Not Write Below This Line

☐ Special health care needs (*If under 14)
☐ Exposed root surfaces
☐ Many multi-surface restorations
☐ Enamel defects (spots, marbled, cracked, worn)
☐ Misalignment
☐ Restoration overhangs, open margins, clasps
☐ Plaque
☐ Other _____

Risk Factors	0	1-2	3+
None	L	H<6 M6+	H
Moderate	M	M	H
High	H	H	H

Caries History in Past 3 Years

Treatment Recommendations: ☐ None ☐ Rx: Fluoride Toothpaste ☐ Fluoride Varnish every 6 months ☐ Fluoride Varnish every 3 months ☐ Chlorhexidine 1 wk/mo ☐ Other _____