Weeks Family Medicine

Oregon Oral Health Coalition Caries Risk Assessment

Last Name:	First:	Date of birth:	Today's date:

Lifestyle Assessment

	YES	NO
Does the child's mother/primary caregiver have active tooth decay? (cavities)		
Does the child consume carbohydrates between meals?		
Does the child receive inadequate systemic fluoride? (Fluoridated water, supplements)		
Does the child use fluoride toothpaste less than twice a day?		
Does the child receive fluoride varnish less than twice a year?		
Does the child need a dental home?		
Is the child receiving any services from WIC, Head Start or Medicaid (OHP)?		
Does the child have any special healthcare needs? (Physical limitations, medications)		

Below is for office use only

Visual Assessment

	YES	NO
Are there visible white spot lesions or decay on the child's teeth?		
Has the child experienced previous caries? (Both treated or untreated)		
Does the child have plaque?		

The patient is at **high** risk if there are two or more YES responses.

Risk: _____Low _____Moderate _____High