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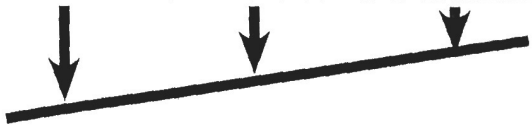
TABLE 1

Caries Risk Assessment Form — Children Age 6 and Over/Adults

Patient Name: _____ Chart #: _____ Date: _____

Assessment Date: Is this (please circle) base line or recall

Disease Indicators (Any one "YES" signifies likely "High Risk" and to do a bacteria test)**	YES = CIRCLE	YES = CIRCLE	YES = CIRCLE
Visible cavities or radiographic penetration of the dentin	YES		
Radiographic approximal enamel lesions (not in dentin)	YES		
White spots on smooth surfaces	YES		
Restorations last 3 years	YES		
Risk Factors (Biological predisposing factors)		YES	
MS and LB both medium or high (by culture**)		YES	
Visible heavy plaque on teeth		YES	
Frequent snack (> 3x daily between meals)		YES	
Deep pits and fissures		YES	
Recreational drug use		YES	
Inadequate saliva flow by observation or measurement (**If measured, note the flow rate below)		YES	
Saliva reducing factors (medications/radiation/systemic)		YES	
Exposed roots		YES	
Orthodontic appliances		YES	
Protective Factors			
Lives/work/school fluoridated community			YES
Fluoride toothpaste at least once daily			YES
Fluoride toothpaste at least 2x daily			YES
Fluoride mouthrinse (0.05% NaF) daily			YES
5,000 ppm F fluoride toothpaste daily			YES
Fluoride varnish in last 6 months			YES
Office F topical in last 6 months			YES
Chlorhexidine prescribed/used one week each of last 6 months			YES
Xylitol gum/lozenges 4x daily last 6 months			YES
Calcium and phosphate paste during last 6 months			YES
Adequate saliva flow (> 1 ml/min stimulated)			YES
****Bacteria/Saliva Test Results: MS: LB: Flow Rate: ml/min. Date:**			



VISUALIZE CARIES BALANCE
(Use circled indicators/factors above)
(EXTREME RISK = HIGH RISK + SEVERE SALIVARY GLAND HYPOFUNCTION)
CARIES RISK ASSESSMENT (CIRCLE): EXTREME HIGH MODERATE LOW

Doctor signature/#: _____ Date: _____

TABLE 5

Self-management Goals for Parent/Caregiver

Patient Name_____ DOB_____

Regular dental visits for child

Family receives dental treatment

Healthy snacks

Brush with fluoride toothpaste at least twice daily

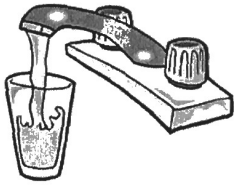
No soda

Less or no juice

Wean off bottle (At least no bottle for sleeping)

Only water or milk in sippy cup

Chew gum with xylitol



Drink tap water

Less or no candy and junk food

IMPORTANT:
The last thing that touches your child's teeth before bedtime is the toothbrush with fluoride toothpaste.

Circle the goals you will focus on between today and your next visit.

On a scale of 1-10, how confident are you that you can accomplish the goals? 1 2 3 4 5 6 7 8 9 10

Not likely Definitely

My promise: I agree to the goals circled and understand that staff may ask me how I am doing with my goals.

Date:_____ Signed by:_____

Review Date:_____ Comments:_____ Staff Initials:____

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