Pt Caries-risk Assessment Questionnaire

Name:		*Visit Date:*	*Patient ID:*
DOB:	*Sex:*	*SSN:*	*MedicTalk ID:*

Questions	*Answers*	Copy
Child has special health care needs, especially any that impact motor coordination or cooperation:		
Child has condition that impairs saliva (dry mouth):		
Child's use of dental care at home (frequent of routine dental visits):		
Child has decay:		
Time lapsed since child's last cavity:		
Child wears braces or orthodontic / oral appliances:		
Child's parents and/or sibling(s) have decay:		
Socioeconomic status of child's parent:		
Daily between meal exposures to sugars / cavity producing foods (includes on demand use of bottle/sipply cup containing liquid other than water; consumption of juice, carbonated beverages, or sports drinks, use of sweetened medications):		
Child's exposure to fluoride (Please use Comments to specify the number): 1-Does not use fluoridated toothpaste; use drinking water w/o fluoride and is not taking fluoride supplements 2-Uses fluoridated toothpastes; usually does not drink fluoridated water and does not take fluoride supplements 3-Uses fluoridated toothpaste; drinks fluoridated water/takes fluoride supplements ***Comments:***		
Time per day that child's teeth/gums are brushed:		
I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE TO THE BEST OF MY KNOWLEDGE.	I Agree	

Doctor's Comments:

Signature: ***Date:***