CARIES RISK ASSESSMENT FORM – CHILDREN AGE 6 AND OVER/ADULTS

Patient Name:_____ **I.D.#**_____ **Age:**_____

Date:_____ **Assessment Date:** _____ **Is this (please circle) baseline or recall**

NOTE: Any one YES in Column 1 signifies likely "High Risk" and an indication for bacteria tests	**YES = CIRCLE**			**Comments:**
	1	**2**	**3**	
1. Risk Factors (Biological Predisposing Factors)				
(a) Has active dental decay in the past year	**YES**			
(b) Frequent **(> 3 times/day)** between-meal snacks		**YES**		# times/day: Types:
(c) Drinks sports beverages		**YES**		# times/day:
(d) Recreational drug/tobacco/alcohol use		**YES**		
(e) Saliva-Reducing factors (medications/radiation/systemic)		**YES**		
(f) Child or adolescent has special health care needs		**YES**		
(g) Orthodontic appliances		**YES**		
2. Protective Factors				
(a) Home/work/school in fluoridated community			**YES**	Zip Code:
(b) Fluoride toothpaste at least 2x daily			**YES**	# times/day:
(c) Fluoride mouthrinse (0.05% NaF) daily			**YES**	
(d) 5000 ppm F fluoride toothpaste daily			**YES**	
(e) Fluoride varnish in last 6 months			**YES**	
(f) Chlorhexidine prescribed/used one week each month during the last 6 months			**YES**	
(g) Xylitol gum/lozenges 4x daily last 6 months			**YES**	
(h) Calcium and phosphate paste during last 6 months			**YES**	
3. Disease Indicators - Clinical Examination				
(a) Visible cavities or radiographic penetration of the dentin	**YES**			
(b) Radiographic proximal enamel lesions (not in dentin)	**YES**			
(c) White spots on smooth surfaces	**YES**			
(d) Restoration in the last 3 years	**YES**			
(e) Plaque is obvious on the teeth and/or gums bleed easily		**YES**		
(f) Visually inadequate saliva flow		**YES**		
(g) Exposed roots		**YES**		
(h) Deep pits and fissures		**YES**		
(i) New remineralization since last visit (List teeth):			**YES**	Teeth:

Overall Caries Risk (circle): HIGH MODERATE LOW

EXTREME RISK=HIGH RISK + SEVERE SALIVARY GLAND HYPOFUNCTION

Bacteria/Saliva Test Results: MS: LB: Flow Rate: ml/min: Date:

Self-management goals:

1. _____

2. _____

Since Last Visit:

New Cavitation: **Y / N**

New White Spot Lesions: **Y / N**

Dental Pain: **Y / N**

Referral Type: **O.R.** **I.V.** **Oral Sedation**

Clinician's Signature: _____ **Date:** _____ (Updated: 8/19/14)