

Caries Risk Assessment Form (Age 0-6)

Patient Name:			
Birth Date:		Date:	
Age:		Initials:	

	Low Risk	Moderate Risk	High Risk
--	----------	---------------	-----------

Contributing Conditions	Check or Circle the conditions that apply		
-------------------------	---	--	--

I.	Fluoride Exposure (through drinking water, supplements, professional applications, toothpaste)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
II.	Sugary Foods or Drinks (including juice, carbonated or non-carbonated soft drinks, energy drinks, medicinal syrups)	Primarily at mealtimes <input type="checkbox"/>	Frequent or prolonged between meal exposures/day <input type="checkbox"/>	Bottle or sippy cup with anything other than water at bed time <input type="checkbox"/>
III.	Eligible for Government Programs (WIC, Head Start, Medicaid or SCHIP)	<input type="checkbox"/> No		<input type="checkbox"/> Yes
IV.	Caries Experience of Mother, Caregiver and/or other Siblings	No carious lesions in last 24 months <input type="checkbox"/>	Carious lesions in last 7-23 months <input type="checkbox"/>	Carious lesions in last 6 months <input type="checkbox"/>
V.	Dental Home: established patient of record in a dental office	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

General Health Conditions	Check or Circle the conditions that apply		
---------------------------	---	--	--

I.	Special Health Care Needs (developmental, physical, medical or mental disabilities that prevent or limit performance of adequate oral health care by themselves or caregivers)	<input type="checkbox"/> No		<input type="checkbox"/> Yes
----	--	-----------------------------	--	------------------------------

Clinical Conditions	Check or Circle the conditions that apply		
---------------------	---	--	--

I.	Visual or Radiographically Evident Restorations/ Cavitated Carious Lesions	No new carious lesions or restorations in last 24 months <input type="checkbox"/>		Carious lesions or restorations in last 24 months <input type="checkbox"/>
II.	Non-cavitated (incipient) Carious Lesions	No new lesions in last 24 months <input type="checkbox"/>		New lesions in last 24 months <input type="checkbox"/>
III.	Teeth Missing Due to Caries	<input type="checkbox"/> No		<input type="checkbox"/> Yes
IV.	Visible Plaque	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
V.	Dental/Orthodontic Appliances Present (fixed or removable)	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
VI.	Salivary Flow	Visually adequate <input type="checkbox"/>		Visually inadequate <input type="checkbox"/>

Overall assessment of dental caries risk: Low Moderate High

Instructions for Caregiver:

Caries Risk Assessment Form (Age 0-6)

Circle or check the boxes of the conditions that apply. Low Risk = only conditions in "Low Risk" column present; Moderate Risk = only conditions in "Low" and/or "Moderate Risk" columns present; High Risk = one or more conditions in the "High Risk" column present.

The clinical judgment of the dentist may justify a change of the patient's risk level (increased or decreased) based on review of this form and other pertinent information. For example, missing teeth may not be regarded as high risk for a follow up patient; or other risk factors not listed may be present.

The assessment cannot address every aspect of a patient's health, and should not be used as a replacement for the dentist's inquiry and judgment. Additional or more focused assessment may be appropriate for patients with specific health concerns. As with other forms, this assessment may be only a starting point for evaluating the patient's health status.

This is a tool provided for the use of ADA members. It is based on the opinion of experts who utilized the most up-to-date scientific information available. The ADA plans to periodically update this tool based on: 1) member feedback regarding its usefulness, and; 2) advances in science. ADA member-users are encouraged to share their opinions regarding this tool with the Council on Dental Practice.