

# Oral Health Assessment Form - Age 0 to 3

We care about your child's oral health. Together, you and your child's dental care team can help create a healthy dental care plan for your child. Please complete this Oral Health Assessment form in order to personalize this care plan for your child.

**Patient Name:** \_\_\_\_\_

**Age:** \_\_\_\_\_

**Date:** \_\_\_\_\_

*Please circle the correct answer for each question below.*

|    |  |     |     |              |
|----|--|-----|-----|--------------|
| 1  | Has mother/father or caregiver had active dental decay or dental fillings in the past 12 months?         | Yes | No  |              |
| 2  | Has your child had any cavities?   | Yes | No  |              |
| 3  | Do other siblings have a history of dental decay?  | Yes | No  |              |
| 4  | Does your child sleep with a bottle or nurse on demand?  | Yes | No  |              |
| 5  | Does your child have continual use of a bottle or sippy cup containing beverages other than plain water? | Yes | No  |              |
| 6  | Does your child frequently snack on candy or carbohydrate snacks?  | Yes | No  |              |
| 7  | Does your child take medications for asthma, seizure or hyperactivity?                                   | Yes | No  |              |
| 8  | Does your child take daily liquid medications?   | Yes | No  |              |
| 9  | Does your child have any developmental problems?   | Yes | No  |              |
| 10 | Does your drinking water contain fluoride?   | No  | Yes | I don't know |
| 11 | Are your child's teeth cleaned with fluoride toothpaste twice daily?                                     | No  | Yes |              |
| 12 | Does your child have a dental home and receive regular dental care?                                      | No  | Yes |              |

***Thank you for your time!***

## For Dental Staff Use Only

Patient Name: \_\_\_\_\_

Age: \_\_\_\_\_

Date: \_\_\_\_\_

❶ Cavitated or Radiographic Lesions?

Yes

No

❷ Inadequate saliva flow?

Yes

No

❸ White spots/demineralization?

Yes

No

❹ Plaque is obvious on teeth?

Yes

No

❺ Gums bleed easily?

Yes

No

❻ Deep pits/fissures?

Yes

No