Patient Name: _____ Date of birth: _____MRN: _____

Oregon Oral Health Coalition Caries Risk Assessment <6

Lifestyle Assessment

	YES	NO
Does the child's mother/primary caregiver have active decay? Tiene la mamá/cuidador del niño(a) caries dentales?		
Does the child consume carbohydrate between meals? ¿Consume su niño(a) carbohidratos entre comidas?		
Does the child receive inadequate systemic fluoride? (fluoridated water, supplements) ¿Su niño(a) recibe inadecuado fluoruro sistémico ? (agua con fluoruro, suplementos)		
Does the child use fluoride toothpaste less than twice daily? ¿Su niño(a) utiliza pasta dental con fluoruro menos de dos veces al día?		
Does the child receive fluoride varnish less than twice a year? ¿El niño(a) recibe barniz de fluoruro menos de dos veces al año?		
Does the child need a dental home? ¿Su niño(a) necesita un hogar dental?		
Is the child receiving any services from WIC, Head Start or Medicaid? ¿Su niño(a) recibe cualquier servicio de WIC, Head Start o Medicaid?		
Does the child have any special healthcare needs? (physical limitations, medications? ¿Su niño(a) tiene necesidades especiales de salud? (limitaciones físicas, medicamentos?		

<u>For office staff use only:</u>

Visual Assessment

	YES	NO
Are there visible white spot lesions or decay on the child's teeth?		
Has the child experienced previous caries? (both treated or untreated)		
Does the child have plaque?		

This child is at **high** risk if there are two or more YES responses.

Risk: ____ Low ____ High