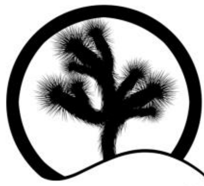

HI-DESERT
FAMILY HEALTH CLINICS
HI-DESERT MEMORIAL HEALTH CARE DISTRICT

Oral Health Risk Assessment

Child's Name________________________ Age_______ DOB__________ Today's Date__________

To help us assess your child's dental needs, please answer these questions. Thank You.

	YES	NO
Health History		
Did birth mother have any problems during pregnancy?	☐	☐
Has your child needed frequent use of liquid medication?	☐	☐
Does your child have any special health care needs?	☐	☐
Notes: _____________________________________		
Have the parents, caregiver seen a dentist in the last year?	☐	☐
Diet and Nutrition		
Is/was your child breastfed?	☐	☐
Does your child sleep with a bottle?	☐	☐
Does your child drink from a Sippy cup or cup?	☐	☐
Does your child eat sweets/carbohydrates or drink juice between meals?	☐	☐
Fluoride		
Do you have public fluoridated water?	☐	☐
Do you have well water?	☐	☐
If yes, has it been tested for fluoride content?	☐	☐
Is your child taking fluoride tablets or drops daily?	☐	☐
Has your child had a fluoride varnish application?	☐	☐
Notes ___________________________________		
Oral Habits		
Does your child have any oral habits?	☐	☐
Notes ___________________________________		
Does your child use a pacifier?	☐	☐
Does you child suck their thumb?	☐	☐
Does your child clench/grind their teeth?	☐	☐
Oral Development		
At what age did your child's first tooth erupt? (in months)______	☐	☐
Has your child experienced teething problems?	☐	☐

Have you or anyone in your family had cavities or dental problems? ☐ ☐
Has anyone checked your child's teeth? ☐ ☐
Have you ever seen white spots or decay on your child's teeth? ☐ ☐
Notes__________________________________

Oral Hygiene

Do you clean your child's teeth/gums? ☐ ☐
Do you use a toothbrush to clean your child's gums and teeth? ☐ ☐
Do you use fluoride or non-fluoride (training) toothpaste? ☐ ☐
Does your child floss their teeth? ☐ ☐
Does anyone in your family have untreated dental needs? ☐ ☐
Notes _____________________________________

Dental Home

Do you have a dentist? ☐ ☐
What is her/his name? ______________________
Does your child have a dental home or dentist? ☐ ☐
What is her/his name? ______________________

Please circle: Mother Father Guardian Signature: ________________________________

Pediatrician or Provider:

Risk Assessment (circle one)	Low	Moderate	High
Oral Hygiene	Good	Fair	Poor

Referral for routine care to dentist ☐YES ☐NO
Pain and/or infection present ☐YES ☐NO
Developmental problems present ☐YES ☐NO
White spot lesions present ☐YES ☐NO
Dental sealants present ☐YES ☐NO
Trauma/signs of abuse present ☐YES ☐NO
Fluoride varnish application completed at this visit ☐YES ☐NO

Comments____
____

Provider signature__________________________
(Print)_____________________________________