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.

❶ Has mother/father or caregiver had active dental decay or dental fillings in the past 12 months?	Yes	No	
❷ Has your child had any cavities?	Yes	No	
❸ Do other siblings have a history of dental decay?	Yes	No	
❹ Does your child sleep with a bottle or nurse on demand?	Yes	No	
❺ Does your child have continual use of a bottle or sippy cup containing beverages other than plain water?	Yes	No	
❻ Does your child frequently snack on candy or carbohydrate snacks?	Yes	No	
❼ Does your child take medications for athsma, seizure or hyperactivity?	Yes	No	
❽ Does your child take daily liquid medications?	Yes	No	
❾ Does your child have any developmental problems?	Yes	No	
❿ Does your drinking water contain fluoride?	No	Yes	I don't know
⓫ Are your child's teeth cleaned with flouride toothpaste twice daily?	No	Yes	
⓬ 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