Oral Health Assessment Form - Age 6 and older

We are honored that you have trusted your oral health with our dental group practice. Together with our dental team of professionals we will provide an exam and evaluate needs, then present our findings to you for your approval. Please complete this Oral Health Assessment form in order to personalize this care plan for you.

Patient Name: _____ **Age:** _____

Date: _____

Please circle the correct answer for each question below.

❶ Have you had a cavity in the last 3 years?	Yes	No	
❷ Do you have dry mouth?	Yes	No	
❸ Do you wear braces, a retainer or any removable appliance?	Yes	No	
❹ Are you taking any medications that cause dry mouth?	Yes	No	
❺ Are you undergoing chemotherapy or radiation therapy?	Yes	No	
❻ Do you have Gastroesophageal Reflux Disease, or Sjogren's syndrome?	Yes	No	
❼ How often do you snack between meals?	3-5	1-3	0-1
❽ Do you use any tobacco products?	Yes	No	
❾ Does your drinking water contain fluoride?	No	Yes	I don't know
❿ Do you brush your teeth twice daily?	No	Yes	
⓫ Do you floss daily?	No	Yes	
⓬ Do you use a fluoride toothpaste?	No	Yes	
⓭ Do you have a dental home and receive regular dental care?	No	Yes	I don't know

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/Calculus?	Generalized	Localized	Minimal
❺ Bleeding gums?	Yes	No	
❻ Deep pits/fissures?	Yes	No	
❼ Exposed root surfaces?	Yes	No	

** Establishing a dental home means that your child's oral health is delivered in a comprehensive, continuously accessible, coordinated and family-centered way. The dental home allows the dental professions to treat and assist children and parents to optimal oral health.*