MORONGO BASIN
COMMUNITY HEALTH CENTER
A SERVICE OF MORONGO BASIN HEALTHCARE DISTRICT

ORAL HEALTH RISK ASSESSMENT

Child's Name _____ Age _____ DOB _____ Today's Date _____

To help us assess your child's dental needs, please answer the following questions.

HEALTH HISTORY	*Yes*	*No*
Did birth mother have any problems during pregnancy?	❑	❑
Has your child needed frequent use of liquid medication?	❑	❑
Does your child have any special healthcare needs?	❑	❑
Have the parents/caregiver seen a dentist in the last year?	❑	❑

NOTES: _____

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DIET AND NUTRITION	*Yes*	*No*
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	*Yes*	*No*
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: _____

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ORAL HABITS	*Yes*	*No*
Does your child have any oral habits?	❑	❑

NOTES: _____

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Does your child use a pacifier?	❑	❑
Does your child suck their thumb?	❑	❑
Does your child clench / grind their teeth?	❑	❑

ORAL DEVELOPMENT	*Yes*	*No*
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: _____

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ORAL HYGIENE	*Yes*	*No*
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: _____

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DENTAL HOME	*Yes*	*No*
Do you have a dentist?	❑	❑
Does your child have a dental home / dentist?	❑	❑

Signature: _____ Relationship to child: ❑Mother ❑Father ❑Guardian

DO NOT WRITE BELOW THE LINE – FOR STAFF USE ONLY

PROVIDER ASSESSMENT:

Risk Assessment: ❑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 this visit	❑Yes	❑No

NOTES: _____

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Provider's signature: _____ Date: _____

Print provider's name _____