



# Pediatric Oral Health Screening

## Medical Office

NAME \_\_\_\_\_  
 DOB \_\_\_\_\_  
 MRN \_\_\_\_\_  
 PCP \_\_\_\_\_  
 Patient ID \_\_\_\_\_

Chief complaint or reason for referral  Initial  Follow-up

Caries risk indicators – based on parent interview	Y	N	Notes
(a) Mother/ primary caregiver has had active dental decay in past 12 months			
(b) Older siblings with history of dental decay			
(c) Continual use of bottle containing beverages other than plain water (nothing added). Bottle use >12 months old			
(d) Child sleeps with a bottle or nurses on demand after any teeth have erupted			
(e) Frequent (greater 3x/day total) candy, carbohydrate snacks, soda, sugared beverages, fruit juice			
(f) Medical Risks: 1. Saliva-reducing meds (asthma, seizure, hyperactivity etc.) 2. Developmental problems etc. 3. History of anemia or iron therapy 4. Daily liquid medications			

Protective factors – based on parent interview	Y	N	Notes
(a) Child lives in fluoridated community AND drinks tap water daily			
(b) Teeth cleaned with fluoridated toothpaste smear twice daily			
(c) Child has a dental home and regular dental care			

Oral examination	Y	N	Notes
(a) Obvious white spots (demineralization) Non-cavitated ECC (V72.2)			
(b) obvious decay present on the child's teeth Cavitated ECC (521.02, 521.03) NOTE ON DIAGRAM White/Brown/Black spots			
(c) Plaque is obvious on the teeth and/or gums bleed easily			

**Assessment: Child's caries risk status (any checked item in shaded areas confers high risk):**

LOW  HIGH

**Plan:**

Oral Health education handouts  Self Management Goals

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

Examples:  
 regular dental visits  
 healthy snacks  
 wean off bottle  
 give fluoride supplement  
 parents receive dental treatment

- Dispense toothpaste and toothbrush
- Tooth brushing & fluoride varnish application
- Oral Health Clinic follow-up appointment (high risk) \_\_\_\_\_ months
- Urgent outside dental referral (high risk, needs tracking)
- Routine dental referral for dental home (all others)

Signature of Rendering Provider: \_\_\_\_\_ Name: \_\_\_\_\_ # \_\_\_\_\_

Supervising Attending: \_\_\_\_\_ # \_\_\_\_\_ Date of Service: \_\_\_\_\_