Oral Health Screening

Today's Date: _____

Patient Name: _____ **Patient's Age**: _____

Dental History

	Yes	No
Does parent/guidance brush teeth daily with fluoridated toothpaste?		
Does child have regular source of dental care (i.e. dental home)?		
Is child put to bed with bottle or sippy cup?		
Does the child frequently snack or drink sugar containing beverages between meals?		
Other comments:		

Visual Exam:

	Yes	No
Does the child have visible plaque on teeth?		
Does the child have any visible white spot lesions?		
Does the child have any cavitated lesions?		
Does the child have fillings, crowns or teeth missing due to cavities?		
Other comments:		

Procedures:

	Yes	No
Was fluoride varnish applied?		
Was child referred to a dentist (i.e. dental home)?		
Was parent educated on oral health care?		
Other comments:		

Provider signature: _____