Caries Risk Assessment

Patient Information

Name: _____

Age: _____ **Gender:** _____ **Date of Assessment:** _____

Dental History: _____

Medical History: _____

Assessment Factors

1. Past Dental History

- Number of cavities in the past year: _____
- Number of restorations: _____
- Presence of previous orthodontic treatment: Yes / No _____

2. Medical History

- Presence of chronic medical conditions: Yes / No _____
- Medications that may affect oral health: _____
- Xerostomia (dry mouth): Yes / No _____

3. Oral Hygiene Habits

- Frequency of brushing: _____
- Type of toothbrush: _____
- Use of fluoride toothpaste: Yes / No _____
- Frequency of flossing: _____

4. Diet and Nutrition

- Frequency of sugary food and beverage consumption: _____
- Snacking habits between meals: _____

5. Salivary Factors

- Presence of reduced salivary flow: Yes / No _____
- pH of saliva: _____

6. Socioeconomic Factors

- Access to dental care: _____
- Socioeconomic status: _____

7. Bacterial Factors

- Presence of Streptococcus mutans or Lactobacillus: Yes / No _____
- Use of antibacterial mouthwash: Yes / No _____

8. Fluoride Exposure

- Fluoridated water source: Yes / No _____
- Use of fluoride supplements: Yes / No _____
- Professional fluoride treatments: Yes / No _____

9. Radiographic Findings

- Presence of interproximal caries: Yes / No _____
- Presence of occlusal caries: Yes / No _____

10. Additional Comments

Caries Risk Assessment:

☐ Low Risk

☐ Moderate Risk

☐ High Risk

Recommendations:

- Dental treatment required: _____
- Oral hygiene instructions: _____
- Diet and nutritional counseling: _____
- Fluoride recommendations: _____
- Recall interval: _____

Provider's Signature: _____ **Date:** _____