Early Childhood Caries Risk Assessment
EHS Pre-Teeth

The following questions are designed to determine the overall risk of dental problems in your child. This assessment helps work toward establishing a dental home and providing continuing preventative care (including fluoride varnish and education).

Child's Name: _____ Pre-Teeth date: _____

Child's date of birth: _____ Child's age today: _____

Dentist the family uses: _____ Child last seen: _____

Yes	No	Unknown	Question:
0	2		Do you look into your child's mouth at least once a week?
2	0		My child has visible cuts and sores on the gums.
2	0		Does the parent (or primary care giver) have cavities? #___
2	0		Does your child have pain, blisters or swelling of the gums?
2	0		Does your child consume sweetened snacks and drinks (including juice) at all?
0	2		Do you clean the inside AND outside of the child's mouth at least twice a day with a wash cloth and with water?
2	0		Is the child going to bed with a bottle or has it for more than one hour at a time?

Score: _____

☐ **0-4 points: Routine Care**

☐ **6-8 points: Refer to Pediatrician**

☐ **Observed pain and/or swelling: Refer to pediatrician for urgent care**

Lesson One Checklist:

☐ Referral to medical provider or pediatrician

☐ Referral to Dental Provider for mother/caregiver

☐ Copy of this assessment form to parent and one copy in child's file

☐ Baby Smiles assessment sticker, complete and place in file on S.O.A.P page

☐ Viewed *Lift the Lip* , filp chart, and *Delta Dental* DVD.

Parent Signature: _____

FE Signature _____ Date _____