American Academy of Pediatrics
Oral Health Risk Intake Form

Welcome to today's visit with your child's provider.

Child's Name:_____ Age: _____ Date: _____

1. What concerns or questions do you have about your child's teeth and mouth today?

2. Does your family have a dentist for regular visits or, if needed, an emergency? ❑ Yes ❑ No
   If so, when did you last visit the dentist? _____

3. Has mother or caregiver had cavities in the past 12 months? ❑ Yes ❑ No ❑ Not sure

4. Has your child had any of these dental treatments in the past 6 months?
   a. Routine dental visit ❑ Yes ❑ No ❑ Not sure
   b. Fluoride varnish painted on your child's teeth (This might have been done during a dental or medical visit.) ❑ Yes ❑ No ❑ Not sure
   c. Fillings, which might be the same color as the tooth or silver-colored ❑ Yes ❑ No ❑ Not sure
   d. Silver diamine fluoride, a liquid that turns black when applied to areas of decay ❑ Yes ❑ No ❑ Not sure

5. Does your child go to bed with a bottle or sippy cup filled with a drink other than water? ❑ Yes ❑ No ❑ Not sure

6. What does your child usually drink? (check all that apply) ❑ Juice ❑ Soda/pop ❑ Energy drinks ❑ Other (please list drink)_____

7. Does your family drink water with fluoride? ❑ Yes ❑ No ❑ Not sure

8. How many times a day do you help your child brush teeth? ❑ 0 ❑ 1 ❑ 2 ❑ More than 2

9. Does your child's toothpaste have fluoride? ❑ Yes ❑ No ❑ Not sure

10. On most days, how many snacks or sugary drinks (like juice, soda, energy drinks) does your child have? ❑ 0 ❑ 1 ❑ 2 ❑ More than 2

Thank you!

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