Teledentistry Caries Risk Assessment

For completion by LIBERTY Staff Dentist.

Member Information:	
First Name:	**Last Name:**
Member Number:	**Date of Birth:**
PROVIDER NAME:	**DATE OF EVALUAION:**

Assessment (check as applicable):				
		Low Risk (0 points)	**Moderate Risk (1 point)**	**High Risk (2 points)**
Contributing Conditions				
I.	**Fluoride Exposure** (through drinking water, supplements, professional applications, toothpaste)	☐ Yes	☐ No	
II.	**Sugary Foods/Drinks** (including juice, carbonated or non-carbonated soft drinks, energy drinks, medicinal syrups)	☐ Primarily at mealtimes		☐ Frequent or prolonged between meal exposures/day
III.	**Caries experience of mother, caregiver, and/or other siblings** (for patients aged 0-14)	☐ No carious lesions in last 24 months	☐ Carious lesions in last 7-23 months	☐ Carious lesions in last 6 months
IV.	**Dental Home** (receiving regular dental care in a dental office within the past 18 months)	☐ Yes	☐ No	
V.	**Brushing with toothpaste containing Fl (OTC or RX)**	☐ Yes (2X daily)	☐ Yes (1X or non Fl)	☐ No or less then 1X daily
General Health Conditions				
I.	**Special health care needs** (developmental, physical, medical, or mental disabilities that prevent or limit performance of adequate oral health care by themselves or caregivers)	☐ No	☐ Yes (over age 14)	☐ Yes (6-14)
II.	**Chemo/radiation therapy**	☐ No		☐ Yes
III.	**Eating disorders**	☐ No	☐ Yes	
IV.	**Medications that reduce salivary flow**	☐ No	☐ Yes	
Clinical Conditions				
I.	**Cavitated carious lesions or restorations** (visually evident)	☐ No new carious lesions or restorations in last 36 months	☐ 1-2 new carious lesions or restorations in last 36 months	☐ 3 or more new carious lesions or restorations in last 36 months **(4 Points)**
II.	**Teeth missing due to caries in past 36 months**	☐ No		☐ Yes
III.	**Dental/orthodontic appliances** (fixed or removable)	☐ No	☐ Yes	
IV.	**Severe dry mouth** (Xerostomia)	☐ No		☐ Yes
Overall Assessment:				
	Dental Caries Risk:	☐ **Low**	☐ **Medium**	☐ **High**

Scoring Instructions

5 POINTS AND UP - HIGH RISK

2-4 POINTS - MEDIUM RISK

0-1 POINT - LOW RISK

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LIBERTY DENTAL PLAN

Questionnaire:

1. *If your child is school age, where does your child attend school?*
   a. *Completely Online b. Home Schooled c. Hybrid (in-person and online) d. In Person*

2. *Has your child ever received school-based health services in the past?*
   a. *Yes b. No*

3. *Due to COVID-19, do you feel comfortable coming into a dental office for an appointment?*
   a. *Yes b. No*

4. *How would you rate the condition of your child's teeth and gums? (circle one)*
   a. *Excellent b. Very good c. Good c. Fair d. Poor*

5. *How many times do you/does your child brush his/her teeth in <u>one</u> day? (circle one)*
   a. *___# (enter #) b. Child does not brush yet c. Does not brush everyday c. Don't know*

6. *How many times a day does your child have sugary drinks or snacks?*
   a. *2 or less b. 3 to 5 c. 6 or more*

7. *During the past 12 months, has your child had frequent or chronic difficulty with any of the following? (Check all that apply)*
   a. *Toothaches (no/yes)*
   b. *Bleeding gums (no/yes)*
   c. *Decayed teeth or cavities (no/yes)*

8. *What was the main reason your child last visited a dentist? (check one)*
   a. *Went in on own for check-up, examination or cleaning*
   b. *Was called in by the dentist for check-up, examination or cleaning*
   c. *Something was wrong, bothering or hurting*
   d. *Went for treatment of a condition that dentist discovered at earlier check-up or examination*
   e. *Other*
   f. *Don't know/don't remember*

9. *During the past 12 months, was there a time when your child needed dental care but could not get it at that time? (check one)*
   a. *No b. Yes c. Don't know/don't remember*