**School-Based Dental Services**

***Dental Assessment***

**Student Information**

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| **First name** | **Last name** | **School** | **Grade** |
| **Birth date** | **Phone** | **Ethnicity** |
| **Parent/Guardian name** | **Language spoken at home** |

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| **1. How long has it been since you’ve visited a dentist?** Less than 1 year  1- 2 years  2 or more years ago  I’ve never been to the dentist**2. During the past year, was there a time when you wanted dental care but couldn’t get it?** Yes Why not? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  No  Don’t know**3. How often do you eat sugary foods such as cakes, cookies, candies, ice cream or sweetened cereals?**Several times/day  Once/day Several times/week Once/week Less than once/week **4. How often do you drink sugary beverages such as soda, fruit juice, chocolate milk, sports drinks (Gatorade)?**Several times/day  Once/day Several times/week Once/week Less than once/week**5. Do you currently use any form of tobacco (cigarettes, chew, cigars, pipes, bidis, cloves, hookah, electric cigs)?**  Yes What kind? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  No |

**To be completed by provider**

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| **Screening Results:**

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| --- | --- | --- | --- | --- |
| **Classification** | 1 No decay | 2 Some suspicious areas | 3 Urgent but not in pain | 4 Urgent in pain |
| **Caries Experience (visible decay and/or fillings)**  Yes  No  |
| **Visible Decay Present** Yes  No  **Sealants Needed** Yes  No  |
| Comments |

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