**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:**   |  |  |  |  |  | | --- | --- | --- | --- | --- | | **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 | | | | |   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Provider name Date** |