School-Based Dental Services

NATIVE AMERICAN HEALTH CENTER

Dental Assessment

Student Information

First name	Last name	School	Grade

Birth date	Phone	Ethnicity

Parent/Guardian name	Language spoken at home

♦♦

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

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