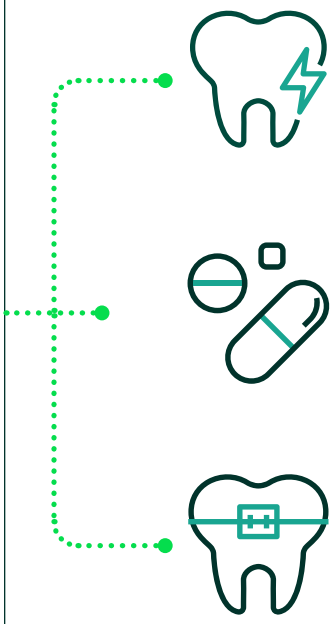
Patient name: _____

Your personalized tooth decay risk

Place a check mark next to all that apply.

Moderate risk factors

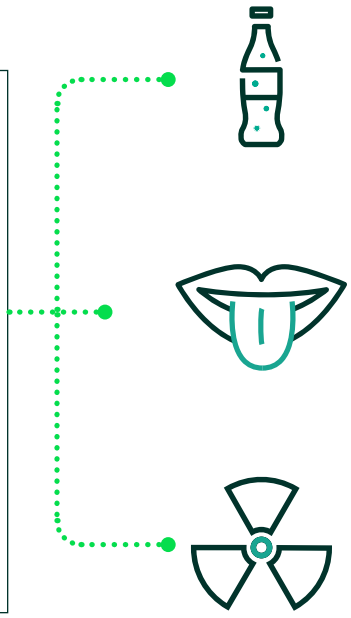
- ☐ I have had one or more cavities in the past 12 months.
- ☐ I brush my teeth one time a day or less.
- ☐ I have orthodontic braces on my teeth.
- ☐ There are people in my family that have problems with cavities.
- ☐ I use bottled water or well water in my home rather than the city water supply.
- ☐ I see a dentist one time per year or less.
- ☐ Some areas in my mouth trap food between my teeth.
- ☐ I use recreational or illegal drugs or abuse alcohol.
- ☐ I have dental fillings in my teeth from previous tooth decay.
- ☐ I have an eating disorder.
- ☐ I have been told I have gum recession.



TIP: Sugary drinks should be consumed within 20 minutes, in order to give your saliva time to neutralize the acid and bring your mouth back to a healthy pH level. If you sip on a can of soda over a long period of time, for example, the environment in your mouth will stay acidic longer – putting you at higher risk.

High risk factors

- ☐ I have had three or more cavities in the last three years.
- ☐ I have had one or more teeth removed due to cavities in the past three years.
- ☐ I consume high sugar or high acid food or drinks more than three times per day (Examples: coffee, soda, carbonated water, energy drinks, juice, candy, cough drops).
- ☐ I have a dry mouth.
- ☐ I have had chemotherapy treatment.
- ☐ I have had radiation therapy to my head or neck area.
- ☐ I have a disability that limits my ability to take care of my teeth.



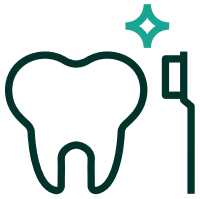
Recommended patient follow-up

Your dentist has determined that you are at risk for developing cavities.
That's why we're recommending the following treatment schedule.

In-office treatments

To schedule, stop by the front desk or call: _____

Treatment	Frequency
In-office fluoride	Every _____ months
Protective sealant	☐ Yes ☐ No
Other: _____	_____



At-home treatments

We recommend these over-the-counter or prescription-strength products for regular use at home.

Treatment	Frequency
Toothpaste: ☐ Over-the-counter ☐ Prescription-strength	per ☐ Day ☐ Week ☐ Month
Fluoride mouth rinse	_____
Other: _____	_____

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