GKAS Tiny Smiles Assessment and Chart

PATIENT'S NAME_____ AGE_____ DATE_____

NAME of CAREGIVER with the CHILD _____ Mother ❑ Father ❑ Other ❑_____

Prenatal, Natal, Neonatal History	Low Risk	High Risk
High Risk Pregnancy	No _____	Yes _____
Tetracycline Ingestion During Pregnancy	No _____	Yes _____
Pre-Term or Low Birth Weight	No _____	Yes _____

Comments:_____

Developmental History

Age First Tooth Erupted _____months

Comments:_____

Medical History	Low Risk	Moderate Risk	High Risk
Number of Ear Infections	0-1	2-3	≥3
Frequency of Antibiotics Prescribed	None	Low	High
Multiple Fevers Early in Life	No		Yes

Other Childhood Illnesses _____

Family History			
Parents Frequency of Decay	Low	Moderate	High
Siblings Frequency of Decay	Low	Moderate	High

Dental History

Previous Dental Trauma _____

Bruxism (Grinding) _____

Teething Difficulties _____

Oral Habits

Sucks Pacifier Yes ____ No ____

Does caregiver clean it in their mouth Yes ____ No ____

Does it get dipped in a sugary substance? Yes ____ No ____ **How Often?**

Sucks Thumb Yes ____ No ____ Only at Night When Sleepy When Bored When Nervous

Sucks Fingers Yes ____ No ____ Only at Night When Sleepy When Bored When Nervous

Home Care

Are teeth being cleaned? No Washcloth Toothbrush **Who is brushing?** Parent Child Parent and child

When are teeth being brushed? Only morning Only night Morning and night After feedings

What toothpaste is being used? None Ingestible (Training) Toothpaste Fluoride Toothpaste

Water and Fluoride Sources

Does your home drinking water have fluoride in it? Yes No Don't Know

Does your child spend time anywhere other than home? Daycare Babysitter Other Caregiver

Does that place have fluoride in the water? Yes No Don't Know

Feeding History

Breast Yes ____ No_____ Until what age? _____	**Low Risk**	**Moderate Risk**	**High Risk**
How many times (circle response)	1-3x day	4-6 x day	Over 6 x day
Duration of feeding	< than 15 minutes	15-30 minutes	> 30 minutes

Feeding on demand _____ Feeding over-night in parent's bed_____

Bottle Yes ____ No_____ Until what age? _____

What's in the bottle? Milk Juice Water Other _____

	Low Risk	Moderate Risk	High Risk
How many times (circle response)	1-3x day	4-6 x day	Over 6 x day
Duration of feeding	< 15 minutes	15-30 minutes	> 30 minutes

Bottle given while lying down Yes _____ No ____
Bottle given as pacifier Yes _____ No ____

Sippy Cup Yes_____ No_____ Until what age?_____

	Low Risk	Moderate Risk	High Risk
How long does the child have the sippy cup each day?	<15 minutes	15-30 minutes	>30 minutes

Snacking and Grazing

Does your child eat sticky snacks? Yes No Fruit snacks Fruit Roll-Ups Dried Fruit Gummy Vitamins

	Low Risk	Moderate Risk	High Risk
How often does your child have between meal snacks?	Never	1-2x a day	>3 times a day
How long is each snacking session?	< 15 minutes	15-30 minutes	All of the time

To be Filled out by Dentist

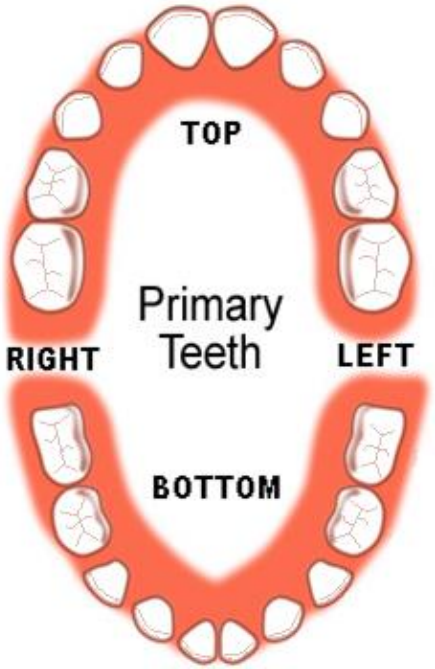
Plaque present on teeth Yes _____ No ____
White/ brown spots or stains on teeth Yes _____ No ____
Decay/cavity present Yes _____ No ____
Has child been to a dentist yet Yes _____ No ____ **Is a Rx required today? Yes _____ No _____**

Does this patient require additional treatment today? Yes_____ No_____

What is needed today? _____
Does this patient require a Smile Factory Office? Yes____ No____ If yes, what treatment is needed?

_____

Dentist's Name _____ Date of last visit _____


TOP
Primary
Teeth
RIGHT
LEFT
BOTTOM



Patient Name_____

DOB_____

CHART OF Services for Tiny Smiles Patient Checkout

Dental Code	Services Rendered	YES	NO	Notes
D0145	*Comprehensive Dental Exam (child 0-2 years)*			
D0150	*Comprehensive Dental Exam (child 3-5 years)*			
D1120	*Prophy: Specify in notes (i.e. gauze, TB, etc.)*			
D1206	*Fluoride Varnish Application*			
D1351	*Sealants: (Place Tooth Numbers in Notes)*			
D1330	*OHI Provided*			
OHS	*Oral Hygiene Supplies given to patient*			
D1310	*Nutritional Counseling Provided*			
9999	*Other Services (Explain in Notes)*			