



## Assessment

Do you have any: (circle all that apply)

Tooth concerns Pain Swelling Bleeding gums "Pink in sink"  
Bad breath Cavities Loose teeth

Do you have a Dental Home where you go routinely?

Dentist/Clinic name \_\_\_\_\_

How long since your last dental visit?

6 months 1 year 1 ½ years 2 years 3years >4 years

Have you experienced morning sickness with this pregnancy?

How many times a day do you brush? \_\_\_\_\_

Do you use Fluoride toothpaste? Y N

Do you floss every day? Y N

## Screening Exam: (circle all that apply)

| Teeth             |             |             |                |       |         |
|-------------------|-------------|-------------|----------------|-------|---------|
| Existing Fillings | White Spots | Brown Spots | Visible Plaque | Decay | Abscess |


| Gums |      |         |     |      |                  |
|------|------|---------|-----|------|------------------|
| Pink | Flat | Swollen | Red | Odor | Visible Calculus |

## Needs Treatment for: (circle all that apply)

| Gums         |            |               |
|--------------|------------|---------------|
| Routine Care | Gingivitis | Periodontitis |

## Teeth Assessment

|             |                |                 |
|-------------|----------------|-----------------|
| No Problems | Early Problems | Urgent Problems |
|-------------|----------------|-----------------|



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