

CRA Form

First name: _____ Last name: _____ Date: _____

Kids Ages 0-5

Risk Factors *Circle one:*

PATIENT USE

Saliva		
My child takes medications daily. (If so, how many?)	NO	YES (_____)
My child seems to have a dry mouth at some point during the day or night.	NO	YES
Diet		
My child continuously sips on something other than water during the day, sleeps with a bottle, or nurses on demand.	NO	YES
My child snacks 1-3 times daily between meals.	NO	YES
Biofilm		
I notice plaque build-up on my child's teeth.	NO	YES

Disease Indicators *Circle one:*

CLINICIAN USE ONLY

Mother/Caregiver active caries?	NO	YES
New/Progressing visible cavitations?	NO	YES
New/Progressing approximal radiographic radiolucencies?	NO	YES
New/Active white spot lesions?	NO	YES
Is decay history a concern?	NO	YES

Risk Identification *Transfer information above to boxes below to determine risk.*

Healthy	+Risk Factors	+Disease Indicators
1 - Low Risk	2 - Moderate Risk	3 - High Risk
CDT Code D0601	CDT Code D0602	CDT Code D0603