

Horizon Dental Care Risk Assessment Form

Name: _____

Date _____

Protective Factors

Electric Toothbrush Twice Daily
Flossing Once Daily
Interproximal Brushes
AirFlosser/Waterpick
Recommended Hygiene Schedule, at least every 6 months
Fluoride Toothpaste
Fluoride Rinse
Fluoride Varnish
Fluoride Gel in Trays
Night Guard
Sleep Apnea Dental Appliance
Xylitol Gum
Whitening in Custom Trays
Other

Damaging Factors

Manual Toothbrush
Irregular Flossing
Grinding Teeth
Clenching Teeth
Smoke Cigarettes, Chewing or Vape with Nicotine
Dry mouth
Candy Habit
Sugar Gum
Acidic Habit, Wine, Soda, Tea, Energy Drinks, La Croix, Fizzy Water
Acid Reflux
Frequent Snacking
Sleep Apnea
Family History of Gum Disease
Family History of Cavities
Other