



Horizon Dental Care Risk Assessment Form

Name: _____


Date: _____

✓	Check the Boxes that apply Circle : <u>Specifics</u>
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Protective Factors

	Electric Toothbrush Twice Daily Circle: Hard, Med, Soft
	Flossing Once Daily Circle: string floss, floss aid 
	Interproximal Brushes 
	AirFlosser/Waterpik
	Recommended Hygiene Schedule Circle: Every 6m, 4m, 3m
	Xylitol/Sugar Free Gum
	Fluoride Varnish
	Fluoride Toothpaste Circle: Prescription
	Fluoride Rinse Circle: Prescription
	Fluoride Gel in Trays
	Whitening Circle: OTC, Custom Trays, In office
	Night Guard Circle: OTC, Custom Made
	Sleep Apnea Dental Appliance
	Other Protective Factors Explain:

Damaging Factors

	Manual Toothbrush Circle: Hard, Med, Soft
	Irregular Flossing Circle: string floss, floss aid 
	Frequent Snacking Circle: Carbs, Fruit, Veggies, Nuts
	Candy Habit
	Dry mouth
	Acid Reflux
	Acidic Habit: Wine, Soda, Tea, Energy Drinks, La Croix, Fizzy Water
	Smoke Cigarettes, Chewing or Vape with Nicotine
	Family History of Gum Disease
	Family History of Cavities
	Clenching Teeth Circle: day, night
	Grinding Teeth
	Sleep Apnea
	Other Damaging Factors Explain:

Low
Medium
High