DENTAL NAVIGATION SHEET

Patient Name:_________________________ DOB:____________ Date:____________

Questions about Parent/Guardian
1. Tell me about your teeth. Have you gone to the dentist for any reason in the past year? ________________
______________________________________________________________________________________________
______________________________________________________________________________________________
2. What about when you were young? Tell me about your teeth then ____________________________
______________________________________________________________________________________________

Questions about Child
1. How do you feel about your child’s dental health? ____________________________
______________________________________________________________________________________________
______________________________________________________________________________________________
2. What do you want for your child’s teeth? ____________________________
______________________________________________________________________________________________
______________________________________________________________________________________________
3. Considering busy schedules, how often do you clean your child’s teeth with fluoridated toothpaste or with a wet rag a week? ____________________________
______________________________________________________________________________________________
______________________________________________________________________________________________
4. What are your views about caring for baby teeth? ____________________________
______________________________________________________________________________________________
______________________________________________________________________________________________
5. Does your child sleep with a bottle? (If the answer is yes, go to question 6)
6. How many nights a week does your child sleep with a bottle? ____________________________
______________________________________________________________________________________________
7 Is a bottle used for drinks throughout the day or only meal time?__________What types of beverages is it filled with? ____________________________
______________________________________________________________________________________________
7. Does your child have snacks frequently? How many times a day? _________What types of snacks? ____________________________
______________________________________________________________________________________________
______________________________________________________________________________________________

Dental Screening
1. Obvious white spots, decalcifications, or obvious decay present on the child’s teeth? _________
______________________________________________________________________________________________
2. Plaque is obvious on the teeth and/or gums bleed easily? ____________________________
______________________________________________________________________________________________
3. Restorations placed in the last 2 years? ____________________________

Practitioner’s Signature: ________________________________________________________________
Navigator’s Signature: ____________________________________________
Screener’s Signature: ____________________________________________

Dental Navigator’s plan:

1) Educate parents about……..
2) Help parents to select at least one self-management goal
3) Follow up with parents in a week or two weeks and help them to identify and address barriers
4) Make sure the child has a follow-up appointment