Firstname	Lastname	HAS ID _____ _____ _____ _____ _____

Date	O Male O Female	DoB	Age (years) O Not sure
Event	Location	O Athlete O Unified partner	Sport
Delegation		SO Program	
Cell phone number		**Number is O Athlete's O Parent's / Guardian 's**	
Providing a phone number is optional. It may be used to call or send reminders if follow up is recommended after screening.			

Screener's name

Dental History

Special Olympics Special Smiles®

Fill out this section for each athlete even if edentulous

1. Do you have a local dentist?
O Yes O No

2. If yes, how often do you visit?
O More than twice a year
O Twice a year
O Once a year
O Less than once a year
O Only when I have a toothache

3. How often do you clean your mouth?
O Once or more a day
O 2 to 6 times per week
O Once per week
O Less than once per week
O Not sure

4. Pain inside mouth
O Yes O No
☐ Teeth
☐ Other

5. ☐ Athlete refused/could not screen

Teeth Screening

6. Edentulous
O Yes (->skip to CAMBRA, otherwise end)
O No (answer all questions 7 thru 18)

7. Untreated decay
(All teeth, lesion greater than 0.5 mm)
O Yes O No
☐ Anterior(s)
☐ Premolar(s)
☐ Molar(s)

8. Filled teeth
(All teeth, no 3rds, Anterior crowns not consider filled)
O Yes O No

9. Missing teeth
(Permanent, Anteriors and Molars Only, no 3rds)
O Yes O No
☐ Anterior(s)
☐ Molar(s)

10. Sealant(s)
(Permanent 1st, 2nd Molars Only)
O Yes O No

11a. Injury
(Permanent Centrals and Incisors Only)
O Yes O No

11b. Injury Treated O Yes O No

12. Fluorosis (Permanent Maxillary Anterior Buccal surface Only)
O Yes O No

13. Gingival signs
(Permanent Mandibular Anterior Buccal)
O Yes O No

14. Treatment urgency
O Maintenance
O Non-urgent
O Urgent

15. Mouth guard recommended
O Yes O No

16. Fluoride Varnish recommended
O Yes O No

Mouth Guard

17. Delivered
O Yes O No

Fluoride Varnish

18. Applied
O Yes O No