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

**Dental History**

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

17. **Delivered**
    - O Yes  O No

18. **Applied**
    - O Yes  O No

Special Smiles