Caries-risk Assessment and Management for Infants, Children, and Adolescents

Review Council
Council on Clinical Affairs
Latest Revision*
2014

**Purpose**
The American Academy of Pediatric Dentistry (AAPD) recognizes that caries-risk assessment and management protocols can assist clinicians with decisions regarding treatment based upon caries risk and patient compliance and are essential elements of contemporary clinical care for infants, children, and adolescents. This guideline is intended to educate health care providers and other interested parties on the assessment of caries risk in contemporary pediatric dentistry and aid in clinical decision making regarding diagnostic, fluoride, dietary, and restorative protocols.

**Methods**
This guideline was originally developed by the Council on Clinical Affairs and adopted in 2002. This document is an update of AAPD’s Policy on Use of a Caries-risk Assessment Tool (CAT) for Infants, Children, and Adolescents, revised in 2006 that includes the additional concepts of dental caries management protocols. The update used electronic and hand searches of English written articles in the medical and dental literature within the last 10 years using the search terms caries risk assessment, caries management, and caries clinical protocols. From this search, 1,909 articles were evaluated by title or by abstract. Information from 75 articles was used to update this document. When data did not appear sufficient or were inconclusive, recommendations were based upon expert and/or consensus opinion by experienced researchers and clinicians.

**Background**

**Caries-risk assessment**
Risk assessment procedures used in medical practice normally have sufficient data to accurately quantitate a person’s disease susceptibility and allow for preventive measures. Even though caries-risk data in dentistry still are not sufficient to quantitate the models, the process of determining risk should be a component in the clinical decision-making process. Risk assessment:

1. Fosters the treatment of the disease process instead of treating the outcome of the disease.
2. Gives an understanding of the disease factors for a specific patient and aids in individualizing preventive discussions.
3. Individualizes, selects, and determines frequency of preventive and restorative treatment for a patient.
4. Anticipates caries progression or stabilization.

Caries-risk assessment models currently involve a combination of factors including diet, fluoride exposure, a susceptible host, and microflora that interplay with a variety of social, cultural, and behavioral factors. Caries risk assessment is the determination of the likelihood of the incidence of caries (i.e., the number of new cavitated or incipient lesions) during a certain time period or the likelihood that there will be a change in the size or activity of lesions already present. With the ability to detect caries in its earliest stages (i.e., white spot lesions), health care providers can help prevent cavitation.

Caries risk indicators are variables that are thought to cause the disease directly (e.g., microflora) or have been shown useful in predicting it (e.g., socioeconomic status) and include those variables that may be considered protective factors. Currently, there are no caries-risk factors or combinations of factors that have achieved high levels of both positive and negative predictive values. Although the best tool to predict future caries is past caries experience, it is not particularly useful in young children due to the importance of determining caries risk before the disease is manifest. Children with white spot lesions should be considered at high risk for caries since these are precavitated lesions that are indicative of caries activity. Plaque accumulation also is strongly associated with caries development in young children. As a corollary to the presence of plaque, a child’s Mutans Streptococci (MS) levels and the age at which a child becomes colonized with cariogenic flora are valuable in assessing risk, especially in preschool children.

While there is no question that fermentable carbohydrates are a necessary link in the causal chain for dental caries, a

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**ABBREVIATIONS**

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* The 2014 revision was limited to use of toothpaste in young children.
systematic study of sugar consumption and caries risk has concluded that the relationship between sugar consumption and caries is much weaker in the modern age of fluoride exposure than previously thought.\textsuperscript{17} However, there is evidence that night-time use of the bottle, especially when it is prolonged, may be associated with early childhood caries.\textsuperscript{18} Despite the fact that normal salivary flow is an extremely important intrinsic host factor providing protection against caries, there is little data about the prevalence of low salivary flow in children.\textsuperscript{19,20}

Sociodemographic factors have been studied extensively to determine their effect on caries risk. Children with immigrant backgrounds have three times higher caries rates than non-immigrants.\textsuperscript{21} Most consistently, an inverse relationship between socioeconomic status and caries prevalence is found in studies of children less than six years of age.\textsuperscript{22} Perhaps another type of sociodemographic variable is the parents’ history of cavities and abscessed teeth; this has been found to be a predictor of treatment for early childhood caries.\textsuperscript{23,24}

The most studied factors that are protective of dental caries include systemic and topical fluoride, sugar substitutes, and tooth brushing with fluoridated toothpaste. Teeth of children who reside in a fluoridated community have been shown to have higher fluoride content than those of children who reside in suboptimal fluoridated communities.\textsuperscript{25} Additionally, both pre- and post-eruption fluoride exposure maximize the caries-preventive effects.\textsuperscript{26,27} For individuals residing in non-fluoridated communities, fluoride supplements have shown a significant caries reduction in primary and permanent teeth.\textsuperscript{28} With regard to fluoridated toothpaste, studies have shown consistent reduction in caries experience.\textsuperscript{29} Professional topical fluoride applications performed semiannually also reduce caries,\textsuperscript{30} and fluoride varnishes generally are equal to that of other professional topical fluoride vehicles.\textsuperscript{31}

Table 1. Caries-risk Assessment Form for 0-3 Year Olds\textsuperscript{39,60}

(For Physicians and Other Non-Dental Health Care Providers)

<table>
<thead>
<tr>
<th>Factors</th>
<th>High Risk</th>
<th>Low Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Biological</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mother/primary caregiver has active cavities</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Parent/caregiver has low socioeconomic status</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Child has &gt;3 between meal sugar-containing snacks or beverages per day</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Child is put to bed with a bottle containing natural or added sugar</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Child has special health care needs</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Child is a recent immigrant</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td><strong>Protective</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child receives optimally-fluoridated drinking water or fluoride supplements</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Child has teeth brushed daily with fluoridated toothpaste</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Child receives topical fluoride from health professional</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Child has dental home/regular dental care</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td><strong>Clinical Findings</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child has white spot lesions or enamel defects</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Child has visible cavities or fillings</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Child has plaque on teeth</td>
<td>Yes</td>
<td></td>
</tr>
</tbody>
</table>

Circling those conditions that apply to a specific patient helps the health care worker and parent understand the factors that contribute to or protect from caries. Risk assessment categorization of low or high is based on preponderance of factors for the individual. However, clinical judgment may justify the use of one factor (e.g., frequent exposure to sugar containing snacks or beverages, visible cavities) in determining overall risk.

Overall assessment of the child’s dental caries risk: High ☐ Low ☐
### Table 2. Caries-risk Assessment Form for 0-5 Year Olds \(^{59,60}\)
(For Dental Providers)

<table>
<thead>
<tr>
<th>Factors</th>
<th>High Risk</th>
<th>Moderate Risk</th>
<th>Low Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Biological</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mother/primary caregiver has active caries</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parent/caregiver has low socioeconomic status</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child ≥3 between meal sugar-containing snacks or beverages per day</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child is put to bed with a bottle containing natural or added sugar</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child has special health care needs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child is a recent immigrant</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Protective</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child receives optimally-fluoridated drinking water or fluoride supplements</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child has teeth brushed daily with fluoridated toothpaste</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child receives topical fluoride from health professional</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child has dental home/regular dental care</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Clinical Findings</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child has &gt;1 decayed/missing/filled surfaces</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child has active white spot lesions or enamel defects</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Child has elevated mutans streptococci levels</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child has plaque on teeth</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Circling those conditions that apply to a specific patient helps the practitioner and parent understand the factors that contribute to or protect from caries. Risk assessment categorization of low, moderate, or high is based on preponderance of factors for the individual. However, clinical judgment may justify the use of one factor (e.g., frequent exposure to sugar-containing snacks or beverages, more than one dmfs) in determining overall risk.

**Overall assessment of the child's dental caries risk:**
- High □
- Moderate □
- Low □

### Table 3. Caries-risk Assessment Form for ≥6 Years Olds \(^{60-62}\)
(For Dental Providers)

<table>
<thead>
<tr>
<th>Factors</th>
<th>High Risk</th>
<th>Moderate Risk</th>
<th>Low Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Biological</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient is of low socioeconomic status</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient ≥3 between meal sugar-containing snacks or beverages per day</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient has special health care needs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient is a recent immigrant</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Protective</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient receives optimally-fluoridated drinking water</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient brushes teeth daily with fluoridated toothpaste</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient receives topical fluoride from health professional</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Additional home measures (e.g., xylitol, MI paste, antimicrobial)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient has dental home/regular dental care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Clinical Findings</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient has ≥1 interproximal lesions</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient has active white spot lesions or enamel defects</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient has low salivary flow</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Patient has defective restorations</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Patient wearing an intraoral appliance</td>
<td></td>
<td></td>
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</tbody>
</table>

Circling those conditions that apply to a specific patient helps the practitioner and patient/parent understand the factors that contribute to or protect from caries. Risk assessment categorization of low, moderate, or high is based on preponderance of factors for the individual. However, clinical judgment may justify the use of one factor (e.g., ≥1 interproximal lesions, low salivary flow) in determining overall risk.

**Overall assessment of the dental caries risk:**
- High □
- Moderate □
- Low □
to disease initiation. Furthermore, the evolution of caries-risk assessment tools and protocols can assist in providing evidence for and justifying periodicity of services, modification of third-party involvement in the delivery of dental services, and quality of care with outcomes assessment to address limited resources and work-force issues.

<table>
<thead>
<tr>
<th>Risk Category</th>
<th>Diagnostics</th>
<th>Interventions</th>
<th>Restorative</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Fluoride</td>
<td>Diet</td>
</tr>
<tr>
<td>Low risk parent engaged</td>
<td>– Recall every six months Baseline MS&lt;sup&gt;a&lt;/sup&gt;</td>
<td>– Twice daily brushing with fluoridated toothpaste&lt;sup&gt;b&lt;/sup&gt;</td>
<td>Counseling</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>– Surveillance&lt;sup&gt;x&lt;/sup&gt;</td>
</tr>
</tbody>
</table>
| Moderate risk parent engaged | – Recall every six months Baseline MS<sup>a</sup> | – Twice daily brushing with fluoridated toothpaste<sup>b</sup> | Counseling | – Active surveillance<sup>6</sup> of incipient lesions
|                      |                                 | – Fluoride supplements<sup>b</sup>                |                                    |
|                      |                                 | – Professional topical treatment every six months  |                                    |
| Moderate risk parent not engaged | – Recall every six months Baseline MS<sup>a</sup> | – Twice daily brushing with fluoridated toothpaste<sup>b</sup> | Counseling, with limited expectations | – Active surveillance<sup>6</sup> of incipient lesions
|                      |                                 |                                                   |                                    |
|                      |                                 | – Professional topical treatment every six months  |                                    |
| High risk parent engaged | – Recall every three months Baseline and follow up MS<sup>a</sup> | – Twice daily brushing with fluoridated toothpaste<sup>b</sup> | Counseling | – Active surveillance<sup>6</sup> of incipient lesions
|                      |                                 | – Fluoride supplements<sup>b</sup>                |                                    |
|                      |                                 | – Professional topical treatment every three months |                                    |
| High risk parent not engaged | – Recall every three months Baseline and follow up MS<sup>a</sup> | – Twice daily brushing with fluoridated toothpaste<sup>b</sup> | Counseling, with limited expectations | – Active surveillance<sup>6</sup> of incipient lesions
|                      |                                 |                                                   |                                    |
|                      |                                 | – Professional topical treatment every three months |                                    |

**Table 4. Example of a Caries Management Protocol for 1-2 Year Olds**

**Table 5. Example of a Caries Management Protocol for 3-5 Year Olds**

<table>
<thead>
<tr>
<th>Risk Category</th>
<th>Diagnostics</th>
<th>Interventions</th>
<th>Restorative</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Fluoride</td>
<td>Diet</td>
</tr>
<tr>
<td>Low risk parent engaged</td>
<td>– Recall every six to 12 months Radiographs every 12 to 24 months Baseline MS&lt;sup&gt;a&lt;/sup&gt;</td>
<td>– Twice daily brushing with fluoridated toothpaste&lt;sup&gt;b&lt;/sup&gt;</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>– Surveillance&lt;sup&gt;x&lt;/sup&gt;</td>
</tr>
</tbody>
</table>
| Moderate risk parent engaged | – Recall every six months Radiographs every six to 12 months Baseline MS<sup>a</sup> | – Twice daily brushing with fluoridated toothpaste<sup>b</sup> | Counseling | – Active surveillance<sup>6</sup> of incipient lesions
|                      |                                 | – Fluoride supplements<sup>b</sup>                |                                    |
|                      |                                 | – Professional topical treatment every six months  |                                    |
| Moderate risk parent not engaged | – Recall every six months Radiographs every six to 12 months Baseline MS<sup>a</sup> | – Twice daily brushing with fluoridated toothpaste<sup>b</sup> | Counseling, with limited expectations | – Active surveillance<sup>6</sup> of incipient lesions
|                      |                                 |                                                   |                                    |
|                      |                                 | – Professional topical treatment every six months  |                                    |
| High risk parent engaged | – Recall every three months Radiographs every six months Baseline and follow up MS<sup>a</sup> | – Brushing with 0.5 percent fluoride (with caution) | Counseling | – Active surveillance<sup>6</sup> of incipient lesions
|                      |                                 | – Fluoride supplements<sup>b</sup>                |                                    |
|                      |                                 | – Professional topical treatment every three months |                                    |
| High risk parent not engaged | – Recall every three months Radiographs every six months Baseline and follow up MS<sup>a</sup> | – Brushing with 0.5 percent fluoride (with caution) | Counseling, with limited expectations | – Active surveillance<sup>6</sup> of incipient lesions
|                      |                                 | – Professional topical treatment every three months |                                    |

**Table 4. Example of a Caries Management Protocol for 1-2 Year Olds**

**Table 5. Example of a Caries Management Protocol for 3-5 Year Olds**
Diagnostics

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for Disease Control and Prevention’s (CDC) recommendations for using fluoride. Guidelines for the use of topical fluoride treatment are based on the ADA’s Council on Scientific Affairs’ recommendations for use of fluoride toothpaste in young children and professionally applied and prescription strength home-use topical fluoride, and the CDC’s fluoride guidelines. Guidelines for pit and fissure sealants are based on the ADA’s Council on Scientific Affairs recommendations for the use of pit-and-fissure sealants. Guidelines on diet counseling to prevent caries are based on two review papers, and evidence-based reviews. Active surveillance (prevention therapies and close monitoring) of enamel lesions is based on the concept that treatment of disease may only be necessary if there is disease progression, and that the majority of proximal lesions, even in dentin, are not cavitated.

Other approaches to the assessment and treatment of dental caries will emerge with time and, with evidence of effectiveness, may be included in future guidelines on caries-risk assessment and management protocols. For example, there are emerging trends to use calcium and phosphate remineralizing solution to reverse dental caries, and other fluoride compounds, such as silver diamine fluoride and stannous fluoride, may be more effective than sodium fluoride for topical applications. There has been interest in antimicrobials to affect the caries rates, but evidence from caries trials is still inconclusive. However, some other proven methods, such as prescription fluoride drops and tablets, may be removed from this protocol in the future due to attitudes, risks, or compliance.

Recommendations
1. Dental caries-risk assessment, based on a child’s age, biological factors, protective factors, and clinical findings, should be a routine component of new and periodic examinations by oral health and medical providers.
2. While there is not enough information at present to have quantitative caries-risk assessment analyses, estimating children at low, moderate, and high caries risk by a preponderance of risk and protective factors will enable a more evidence-based approach to medical provider referrals, as well as establish periodicity and intensity of diagnostic, preventive, and restorative services.
3. Clinical management protocols, based on a child’s age, caries risk, and level of patient/parent cooperation, provide health providers with criteria and protocols for determining the types and frequency of diagnostic, preventive, and restorative care for patient specific management of dental caries.

References