Delta Dental of Arkansas Oral Health Care Periodicity Table

	6-12 months	12-24 months Annually	2-6 years Annually	6-12 years Annually	>12 years Annually
Clinical oral examination[1]	X	X	X	X	X
Assess oral growth and development[2]	X	X	X	X	X
Caries-risk assessment[3]	X	X	X	X	X
Prophylaxis & topical fluoride		X	X	X	X
Fluoride supplementation[5,6]	X	X	X	X	X
Anticipatory guidance[7]	X	X	X	X	X
Oral hygiene counseling for parents, guardians, and/or caregivers[8]	X	X	X	X	
Oral hygiene counseling to patient			X	X	X
Dietary counseling[9]	X	X	X	X	X
Injury prevention counseling[10]	X	X	X	X	X
Counseling for nonnutritive habits[11]	X	X	X	X	X
Substance abuse counseling				X	X
Counseling for intraoral and perioral				X	X
Radiographic assessment[12]	X	X	X	X	X
Treatment of dental disease/ injury	X	X	X	X	X
Assessment and treatment of developing malocclusion			X	X	X
Pit and fissure sealants[13]			X	X	X
Assessment and/or removal of third					X
Referral for regular and periodic dental					X

SAMPLE

1. At the first sign of tooth eruption by the primary care provider and with each subsequent visit to determine if the child needs a referral to a dental provider. Dental examinations by a qualified dental provider should begin between the ages of two and three (unless otherwise indicated) and once yearly thereafter.
2. By clinical examination.
3. As per AAPD "Policy on the use of a caries-risk assessment tool (CAT) for infants, children, and adolescents."
4. Especially for children at high risk for caries and periodontal disease. Additionally, children should be seen for prophylaxis once every 184 days.
5. As per AAPD and American Dental association guidelines and the water source.
6. Up to at least 16 years.
7. Appropriate discussion and counseling should be an integral part of each visit for care.
8. Initially, responsibility of parent; as child develops, jointly with parents; then, when indicated, only child.
9. At every appointment, discuss the role of refined carbohydrates, frequency of snacking.
10. Initially play objects, pacifiers, car seats; then when learning to walk, sports and routine playing.
11. At first discuss the need for additional sucking; digits vs. pacifiers; then the need to wean from the habit before malocclusion or skeletal dysplasia occurs. For school-aged children and adolescent patients, counsel regarding any existing habits such as fingernail biting, clenching, or bruxism.

12. Timing, selection, and frequency determined by child's history, clinical findings, and susceptibility to oral disease.
13. For caries-susceptible primary molars, permanent molars, premolars, and anterior teeth with deep pits and/or fissures; placed as soon as possible after eruption.

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