2014-2015

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For children who are 3 and older.

District of Columbia Oral Health (Dental Provider) Assessment Form

Part 1. Child's Personal Information

Child's Last Name	Child's First & Middle Name	Date of Birth	Gender: ☐M ☐F	School or Child Care facility:

Parent/Guardian Name	Telephone1: ☐Home ☐Cell ☐Work	Home Address:	Ward

Emergency Contact:	Telephone2: ☐Home ☐Cell ☐Work	City/State (if other than D.C.)	Zip code:

Race/Ethnicity: ☐ White Non Hispanic ☐ Black Non Hispanic ☐ Hispanic ☐ Asian or Pacific Islander ☐ Other_____

Primary Care Provider (Medical):	Dentist/Dental Provider:	☐Medicaid ☐Private Insurance ☐None ☐Other_____

Part 2. Child's Clinical Examination (to be completed by the Dental Provider) Date of Exam _____

(Please use key to document all findings on line next to each tooth)

Tooth #	Tooth #	Tooth #	Tooth #
1 _____	17 _____	A _____	K _____
2 _____	18 _____	B _____	L _____
3 _____	19 _____	C _____	M _____
4 _____	20 _____	D _____	N _____
5 _____	21 _____	E _____	O _____
6 _____	22 _____	F _____	P _____
7 _____	23 _____	G _____	Q _____
8 _____	24 _____	H _____	R _____
9 _____	25 _____	I _____	S _____
10 _____	26 _____	J _____	T _____
11 _____	27 _____		
12 _____	28 _____		
13 _____	29 _____		
14 _____	30 _____		
15 _____	31 _____		
16 _____	32 _____		

Key (Check Appropriate)

S - Sealants

X - Missing teeth

Restoration

Non-restorable/ Extraction

1D-One surface decay

UE- Unerupted Tooth

2D-Two surface decay

3D-Three surface decay

4D-More than three surface decay

Part 3. Clinical Findings and Recommendations (Please indicate in Finding column)

	Findings	Comments
1. Gingival Inflammation	Y N	
2. Plaque and/or Calculus	Y N	
3. Abnormal Gingival Attachments	Y N	
4. Malocclusion	Y N	
5. Other (e.g. cleft lip/palate)		

Preventive services completed ☐ Yes ☐ No

Part 4. Final Evaluation/Required Dental Provider Signatures

This child has been appropriately examined. Treatment ☐ is complete ☐ is incomplete. Referred to

DDS/DMD Signature	Print Name	Date

Address

Phone	Fax

Part 5. Required Parent/Guardian Signatures

Parent or Guardian Release of Health Information.

I give permission to the signing health examiner or facility to share the health information on this form with my child's school, childcare, camp, or Department of Health

PRINT NAME of parent or guardian

SIGNATURE of parent or guardian	Date

Top Copy- School Nurse/DC Oral Health Program

Forms are available online at www.dchealth.dc.gov

2nd Copy- Oral Health Provider

5/24/01