CONFIDENTIAL FORM- SIDE ONE

Please review instructions on side two

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