

Instructions

- Complete Part 1 below. Take this form to the child/student's dental provider. The dental provider should complete Part 2.
- Return fully completed and signed form to the student's school/childcare facility.

Part 1: Child/Student Information (To be completed by parent/guardian)

First Name _____ Last Name _____ Middle Initial _____

School or Child Care Facility Name _____

Student ID _____ Date of Birth

		/			/				
--	--	---	--	--	---	--	--	--	--

(MMDDYYYY):

Current Gender Identity: _____

Home Address: _____ Home State: _____ Home Zip Code

--	--	--	--	--

School Grade	Day- care	Pre-K3	Pre-K4	K	1	2	3	4	5	6	7	8	9	10	11	12	Adult Ed.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Part 2: Child/Student's Oral Health Status (To be completed by the dental provider)

- | | | | | |
|--|--------------------------|--------------------------|--------------------------|--------------------------|
| | Yes | No | | |
| 1. Does the patient have at least one tooth with apparent cavitation (untreated caries)? This does NOT include stained pit or fissure that has no apparent breakdown of enamel structure or non-cavitated demineralized lesions (i.e. white spots). | <input type="checkbox"/> | <input type="checkbox"/> | | |
| 2. Does the patient have at least one treated carious tooth ? This includes any tooth with amalgam, composite, temporary restorations, or crowns as a result of dental caries treatment. | <input type="checkbox"/> | <input type="checkbox"/> | | |
| 3. Does the patient have at least one permanent molar tooth with a partially or fully retained sealant ? | <input type="checkbox"/> | <input type="checkbox"/> | | |
| 4. Does the patient have untreated caries or other oral health problems requiring care before his/her routine check-up? (Early care need) | <input type="checkbox"/> | <input type="checkbox"/> | | |
| 5. Does the patient have pain, abscess, or swelling? (Urgent care need) | <input type="checkbox"/> | <input type="checkbox"/> | | |
| 6. How many primary teeth in the patient's mouth are affected by caries that are either: | | | | |
| a. Untreated <table border="1" style="display: inline-table; border-collapse: collapse;"><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr></table> | | | | |
| | | | | |
| b. Treated with fillings/crowns? <table border="1" style="display: inline-table; border-collapse: collapse;"><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr></table> | | | | |
| | | | | |
| 7. How many permanent teeth in the patient's mouth are affected by caries that are either: | | | | |
| a. Untreated <table border="1" style="display: inline-table; border-collapse: collapse;"><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr></table> | | | | |
| | | | | |
| b. Treated with fillings/crowns <table border="1" style="display: inline-table; border-collapse: collapse;"><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr></table> | | | | |
| | | | | |
| c. Extracted due to caries? <table border="1" style="display: inline-table; border-collapse: collapse;"><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr></table> | | | | |
| | | | | |
| 8. What type of dental insurance does the patient have? | Medicaid | Private Insurance | Other | None |
| | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Dental Provider Name _____	Dental Office Stamp
Dental Provider Signature _____	
Dental Examination Date _____	

This form replaces the previous version of the DC Oral Health Assessment Form used for entry into DC Schools, all Head Start programs, and childcare centers. This form is approved by the DC Health and is a confidential document. Confidentiality is adherent to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) for the health providers and the Family Education Right and Privacy Act (FERPA) for the DC Schools and other providers.