|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Initial Dental Exam** | | | | | | | |
| **General Information** (to be completed by shelter staff) | | | | | | | |
| **Child** | Last name: | | | First name: | | | |
| DOB:  \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_ | A#: | | | | Gender: | |
| **Healthcare Provider** | Name: | | Phone number: | | Clinic or Practice: | | |
| Street address: | | City or Town: | | State: | | Date of visit:  \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_ |
| **Program** | Name of program staff with child: | | | Program name: | | | |
| **Assessment and Plan** (To be completed by clinician) | | | | | | | |
| **Assessment:**  Check all that apply and describe where applicable. | | | | | | | |
| * Well-child/No obvious problem | | | | | | | |
| * Broken tooth or teeth: | | | | | | | |
| * Gingivitis/gum disease: | | | | | | | |
| * Impacted tooth or teeth: | | | | | | | |
| * Infection or abscess: | | | | | | | |
| * Tooth decay/caries:   If yes, how many? | | | | | | | |
| * Tooth sensitivity: | | | | | | | |
| * Other, specify: | | | | | | | |
| **Plan:**  Check all that apply and specify in the space provided. | | | | | | | |
| Return to clinic:   * PRN/As needed * Follow-up (specify condition, timing): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | |
| * Referred to specialist; specify: | | | | | | | |
| * Other, specify: | | | | | | | |
| **Additional Information:** | | | | | | | |
|  | | | | | | | |

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