

## Washtenaw ISD Early Childhood Programs Dental Exam

Patient Information (child or pregnant woman)								
Name Date of Birth Date of Exam  This practice is the patient's Dental Home?   Yes  No								
Current Oral Health								
Does the patient have any teeth with untreated decay?								
Does the patient ha	•		have pre	viously been trea	ated for	decay,	es □N	lo
Does the patient have gum disease? □ Yes □ No								lo
Are there treatment needs?								lo
Oral Health Care Se	ervices De	livered	During Vi	sit				
Diagnostic/Preventive Services			Caries Risk Assessment			Restorative/Emergency Care		
Examination:	□ Yes	□ No	□ High	□ Medium □	Low	Fillings:	□ Yes	□ No
X-rays:	□ Yes	□ No				Crowns:	□ Yes	□ No
Cleaning:	□ Yes	□ No	Refer	ral to Specialty C	<u>Care</u>	Extractions:	□ Yes	□ No
Fluoride varnish:	□ Yes	□ No		□ Yes □ No		Emergency Care:	□ Yes	□ No
Dental sealants:	□ Yes	□ No	Specify:			Other:		
Future Oral Health	Care Serv	vices						
All treatment comp	leted:			□ Yes	□ No			
More appointments needed for treatments? □ Yes □ No								
If yes, approximate	number o	of appoi	ntments r	needed:				
Next appointment D				Γime: _				
Health Provider Co	ntact Info	rmatio	n and Sigr	nature				
Print Provider Name	:							
Address:								
Phone #:		·		FAX #:				
Provider Signature				 Date of S	Signatu	 re		



