Washtenaw ISD
A REGIONAL EDUCATIONAL SERVICE AGENCY

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?	□ Yes	□ No
Does the patient have any teeth that have previously been treated for decay, fillings, crowns, or extractions?	□ Yes	□ No
Does the patient have gum disease?	□ Yes	□ No
Are there treatment needs?	□ Yes	□ No

Oral Health Care Services Delivered During Visit

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	**Referral to Specialty Care**	Extractions:	□ Yes	□ No
Fluoride varnish:	□ Yes	□ No	□ Yes □ No	Emergency Care:	□ Yes	□ No
Dental sealants:	□ Yes	□ No	Specify:	Other:		

Future Oral Health Care Services		
All treatment completed:	□ Yes	□ No
More appointments needed for treatments?	□ Yes	□ No
If yes, approximate number of appointments needed:		

Next appointment Date: _____ **Time:** _____

Health Provider Contact Information and Signature

Print Provider Name: _____

Address: _____

Phone #: _____ FAX #: _____

_____ _____

Provider Signature **Date of Signature**

Date program rcvd & initials: _____