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: _____